

2018 Ambulatory Health Care National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

- NPSG.01.01.01 Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
- NPSG.01.03.01 Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Use medicines safely

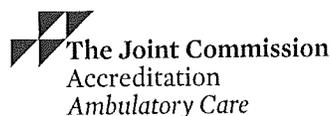
- NPSG.03.04.01 Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
- NPSG.03.05.01 Take extra care with patients who take medicines to thin their blood.
- NPSG.03.06.01 Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Prevent infection

- NPSG.07.01.01 Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
- NPSG.07.05.01 Use proven guidelines to prevent infection after surgery.

Prevent mistakes in surgery

- UP.01.01.01 Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
- UP.01.02.01 Mark the correct place on the patient's body where the surgery is to be done.
- UP.01.03.01 Pause before the surgery to make sure that a mistake is not being made.



This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

SURGERY CENTER OF RENO

Section: 5.3

Policy: Quality Management and Improvement

Subject: SENTINEL EVENT REPORTING

Effective Date: 2-06

Revised: 2-07, 2-08

Page 1 of 3

Reviewed: 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15

3-16, 3-17, 3-18

PURPOSE:

To comply with mandatory reporting requirements in the State of Nevada for sentinel event healthcare occurrences. To define a sentinel event and incorporate root cause analysis documentation into the risk management program of the surgical center. This policy is also an adjunct to the adverse event policy.

DEFINITIONS:

- A. A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes a loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function. Such events are called "sentinel" because they signal the need for immediate investigation and response.
- B. Root cause analysis is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determines, after analysis that no such improvement opportunities exist.
- C. Sentinel events include but may not be limited to the following (even if the outcome was not death or major permanent loss of function):
 - Suicide of a patient in a setting where the patient receives around-the[-]clock care (e.g., hospital, residential treatment center, crisis stabilization center)
 - Infant abduction or discharge to the wrong family
 - Rape
 - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
 - Surgery on the wrong patient or wrong body part
 - Loss of limb or function

SURGERY CENTER OF RENO

Section: 5.3

Policy: QUALITY MANAGEMENT AND IMPROVEMENT

Subject: SENTINEL EVENT REPORTING

Effective Date: 2-06

Revised: 2-07, 2-08

Page 2 of 3

**Reviewed: 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15
3-16, 3-17, 3-18**

PROCEDURAL DOCUMENTATION:

- A. Any event will be handled as described in the Center's incident reporting policy.
- B. If an event is verified as a Sentinel Event (as noted above), a root cause analysis will be initiated by the Administrator and Clinical Managers within 72 hours of the incident in coordination with the attending physician, the unit staff and the administrator, and any other providers identified by the facility who should participate. The root cause analysis will be completed within thirty days. All other incidents will follow the center's policies on investigation and documenting an occurrence or incident that requires analysis and peer review.
- C. Sentinel Events as identified above will be reported to the Administrator, Director/Clinical Managers, Medical Director, and legal counsel as per policy as soon as the facility discovers that the event occurred. A root cause analysis will be completed within 30 days and will be available for peer review.
- D. Qualifying sentinel events will be reported through Peer Review of the Medical Staff and monitored through that committee's discussions and recommendations as reflected in their meeting minutes.
- E. Intensive assessment, action plan and evaluation of the action plan will be completed by the Incident Team on the Root Cause Analysis form. A performance improvement plan should be initiated to improve individual and organizational performance where the need is identified.
- F. Root cause analysis action plan and documentation of the investigation will be maintained by the Risk Manager. All related documents are considered documents protected under peer review and are not to be released without an accompanying court order.
- G. Aggregate statistics will be maintained by the Administrator and reported to the Board of Directors.
- H. Per (NRS) 439.800-890 and (NAC) 439.900-920, mandatory reporting of sentinel events are required by ambulatory surgery centers in the state of Nevada. See attached reporting guide, forms to be completed, and contact information.

SURGERY CENTER OF RENO

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Page 3 of 3

**Reviewed: 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15
3-16, 3-17, 3-18**

Who Should Know This Policy

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Pre-Op Staff | <input checked="" type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Clinical Managers |
| <input checked="" type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input checked="" type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |
| <input checked="" type="checkbox"/> Director of Nursing | <input type="checkbox"/> Business Office Manager | <input checked="" type="checkbox"/> Regional Director |

The following positions are responsible for the accuracy of the information contained in this document:

- Governing Board
- Administrator
- Medical Director
- Clinical Managers
- Business Office Manager
- Director of Nursing

SURGERY CENTER OF RENO

Section 8, D Environment of Care Management Plan

Policy: Facilities and Environment

Subject: Environment of Care Emergency Management Plan, Codes

Effective Date: 2-06

Revised: 2-08, 5-17, 8-17, 10-17, 9-18

Page 1 of 5

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,
3-16, 3-17, 3-18

ENVIRONMENT OF CARE MANAGEMENT PROGRAMS AND EMERGENCY PLAN

POLICY:

The SCOR QI Committee and Medical Executive Committee will support the establishment and maintenance of an effective and comprehensive Environment of Care Management Program reflected in the Regent Surgical Health – Risk Management Manual – May 2008. The QI Committee and MEC will do so by providing:

- Communication regarding general policies and procedures.
- Review reports of key incidents, accidents and trends that may compromise the safety of patients, visitors or staff; actions taken; and the effectiveness of actions taken.
- The Environment of Care Management Programs incorporates all aspects of operations at SCOR. They are based on the monitoring and evaluation of seven (7) main Environment of Care Plans and respective policies and procedures as outlined in the Risk Management Manual. These plans are reviewed at least annually or as various issues arise on an ongoing basis. The objectives, scope, performance, and effectiveness of the Center's Emergency management program are evaluated annually and changes are made to improve the plan are based on committee recommendations.

- I. Safety Management Plan
- II. Security Management
- III. Hazardous Materials and Waste Management
- IV. Emergency Preparedness Program
- V. Fire Prevention Management Plan
- VI. Medical Equipment Management
- VII. Utilities Management

- **CODE RED – FIRE**
- **CODE BLUE – CARDIAC ARREST**
- **CODE YELLOW – INTERNAL / EXTERNAL DISASTER, BIOTERRORISM**
- **CODE BLACK – BOMB THREAT**
- **CODE GREY – SEVERE / INCLEMENT WEATHER** (Thunderstorm, Snow & Ice Storms, Tornado Warning)
- **CODE WHITE – EMERGENCY ASSISTANCE** (Disorderly or Violent Behavior)
- **CODE PURPLE – PLANT EMERGENCY / UTILITY INTERRUPTION** (EOC – Utilities Mgmt.)
- **CODE MH – Malignant Hyperthermia Crisis Code**
- **CODE PINK – CHILD ABDUCTION & MISSING CHILD** (EOC – Security Mgmt.)
- **CODE SILVER – ACTIVE SHOOTER**

SURGERY CENTER OF RENO

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Page 2 of 5

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,
3-16, 3-17, 3-18

PROCEDURE:

- A. The SCOR's Administrator and Medical Director in collaboration with the QI Committee / MEC are responsible to oversee and ensure the objectives of all seven (7) programs are being met.
- B. The QI Committee will analyze identified environment of care management issues and develop recommendations for resolving them. The Committee's will meet on a quarterly basis and forward any recommendations on to the Governing Board as appropriate.
- C. The plan provides processes for:
 - a. Identifying specific procedures in response to a variety of disasters based on a hazard vulnerability analysis performed by the administrator/safety officer/DON;
 - b. Initiating the plan (including a description of how, when, and by whom the plan is activated);
 - c. Defining and, when appropriate, integrating with the surgery center's role in community wide emergency response agencies (including the identification of who is in charge of what activities and when they are in charge) to promote interoperability between the center and the community;
 - d. Coordination and sharing of resources between facilities through HAVBED/IHCC.
 - e. Notifying external authorities of emergencies;
 - f. Notifying personnel when emergency response measures are initiated;
 - g. Identifying personnel during emergencies;
 - h. Assigning available personnel in emergencies to cover all necessary staff positions;
 - i. Managing the following during emergencies and disasters:
 - Patients' activities including scheduling, modifying, or discontinuing services, control of patient information, and patient transportation;
 - Staff activities (for example, housing, transportation, and incident stress debriefing);
 - Staff-family support activities;
 - Logistics of critical supplies (for example, pharmaceuticals, medical supplies, food supplies, linen supplies, water supplies);
 - Security (for example, access, crowd control, traffic control); or
 - Interaction with the news media;
 - j. Evacuating the entire facility when the environment cannot support adequate patient care and treatment;
 - k. See attached emergency phone list and SCOR staff phone list for contact information
 - l. Establish an alternative care site that has the capabilities to meet the clinical needs of patient population served within the center when the environment cannot support adequate patient care including processes that address, when appropriate:

SURGERY CENTER OF RENO

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Page 3 of 5

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18

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- Management of patient necessities such as medications and medical records to and from the alternative care site
 - Patient tracking to and from the alternative care site
 - Inter-facility communication between the hospital and the alternative care site
 - Transportation of patients, staff and equipment to the alternative care site.

D. As appropriate, the plan may be activated by the Administrator, the Safety Officer or the person of highest authority. This individual will establish a centralized command post (generally pre op), which will be announced to all staff members. The facility Administrator will serve as the coordinator of all disaster-related activities. If the facility administrator is not available, the Director of Nursing or Safety Officer shall assume the role of the coordinator, followed by the person of highest authority. The command post will serve as a clearinghouse for information and assignments regarding the disaster. Supply, space, security, and patient management will be directed by the command post coordinator, as appropriate, based on the size, type, and complexity of the disaster. The disaster coordinator will assign an individual to handle all interactions with the news media regarding the disaster as well as the release of any information to the families of patients and/or victims.

E. Through HAVBED, the disaster coordinator will communicate with the local Emergency Management Department officials to determine, based on the size and scope of services, if SCOR will participate in local Emergency Preparedness Drills and disasters. The Administrator and DON are registered with the Washoe County IHCC for emergency notifications via email, home and cell phones, on situations affecting the community. Notifying the local 911 services typically does this. Attached is the Washoe County Medical Unit leader contact list for direct notification to community leaders. Alternate methods of communication have been identified in the event there is a loss of telephone service. These include, but are not limited to, the use of digital pagers, cellular telephones, battery-operated radios, etc. Provided there is no danger to employees by leaving the building, Business Office personnel will be assigned, as appropriate, to travel by personal car to locate public telephones or to notify appropriate authorities such as Police, Fire and Emergency Medical Services of needed assistance.

F. At the discretion of the facility administrator, or designee, off-duty personnel will be notified to report to the facility as needed (see SCOR emergency call tree). For security purposes, i.e., access, crowd control, traffic control, etc., personnel will be identified by the use of their name badge. All personnel will report to the command post for specific assignments.

G. In the event of an actual disaster, the facility Administrator or designee will make the determination as to whether services will be continued, modified, or discontinued as appropriate. When it is determined that the environment cannot support adequate patient care and treatment, the decision will be made to evacuate the entire facility. The Administrator and/or safety officer

SURGERY CENTER OF RENO

Section 8, D Environment of Care Management Plan

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Revised: 2-08, 5-17, 8-17, 10-17, 9-18

Page 4 of 5

**Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,
3-16, 3-17, 3-18**

will make this decision. The emergency management plan addresses specific procedures to be followed in the event an evacuation of the facility is deemed appropriate, as well as alternate roles and responsibilities of key personnel. See individual policies on each disaster scenario under facilities and environment. Communication of Center closure or surgery cancellations will be performed by the management team. In the event of an emergency during operational hours, the receptionist will keep a detailed log of each patient and their families disposition, by referencing the surgical schedule for that day and report to the Administrator or Alternate of any persons not accounted. Referencing the staffing schedule, the nurse manager will validate the location and safety of all staff members and track their location in the event of an evacuation.

H. SCOR provides orientation and annual training for personnel in emergency preparedness. Drills, roles, communication, evacuation training and supplies are reviewed in the annual training and during mock disaster drills. Participation in a community based disaster drill will be conducted annually in coordination with the IHCC Inter-Hospital Coordinating Council. The Center will, in addition to the community based drill, conduct a full scale drill that is facility based. The drills will be documented and analyzed for the facilities response and revise the emergency plan as needed.

I. Medical records will be maintained in the current manner in paper. All medical records will preserve patient information, protect confidentiality and be kept in a secure manner. Copies of the medical record will be sent with the patient in the event of an emergent transfer.

J. The surgery center has initiated a transfer agreement with Saint Mary's Hospital, Northern Nevada Medical Center and Renown Medical Center to establish an alternative care site in the event that the environment cannot support adequate patient care and treatment. The safe transportation of patients, staff and equipment, as well as any patient necessities will be coordinated with local authorities and Emergency Medical Service providers. Staff responsibilities will be assigned according to the staff members competency and department. Inter-facility communication between the facility and the alternative care site will be managed with the assistance of local authorities in the event normal communications are interrupted. The Surgery Center is not designed or licensed to shelter. In the event of an emergency, such as inclement weather, the policy and procedure is to cancel surgeries, cease all operations, and close (meaning there will be no patients or staff in the facility) upon first notification of any event that would normally call for sheltering. All patients would be considered discharged or evacuated per arrangements detailed in our transportation and transfer agreements. It is not the primary goal of the ASC to Shelter in place. Transfer of patients and staff will be the initial emergency plan. In the event that the transfer of staff and patients is deemed not safe, the Administrator will contact the community and county emergency management officials to coordinate the length of time and needs of staff and patients within the ASC. The Center is supplied with emergency food and water in the event of a shelter in place scenario.

SURGERY CENTER OF RENO

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Page 5 of 5

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18

K. In the event of a community wide disaster and the ASC is safe to continue services, the Administrator will be responsible for contacting the local hospitals to verify if the transfer agreement is valid during an extended community recovery phase. If the hospitals remain on divert, the surgery center may not open for scheduled surgeries.

L. Should local emergency authorities request that the center maintain operations for disaster victims the center will obtain an 1135 waiver by following the guidelines listed on the Medicare website: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers.html>

M. In the event of a community disaster where emergency resources such as staff and supplies are necessary, the IHCC incident commander will notify SCOR Administrator or Director of Nursing with instructions. SCOR management will gather available supplies or call staff via the emergency call tree to attain volunteers to report to the emergency. Emergency credentialing paperwork for employees will consist of:

1. Picture ID
2. Nursing license
3. ACLS, PALS, BLS certifications (preferable with e-card number)
4. TB test record

Staff will be issued temporary emergency disaster privileges, issued a badge and assigned a position and proctor appropriate for the staff's competency. SCOR staff will be financially compensated thru SCOR payroll. SCOR will be responsible for seeking reimbursement from the appropriate hospital.

Who Should Know This Policy

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| <input type="checkbox"/> Pre-Op Staff | <input checked="" type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Clinical Managers |
| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |

The following positions are responsible for the accuracy of the information contained in this document:

- Governing Body Administrator Medical Director Clinical Managers
 Director of Nursing

SURGERY CENTER OF RENO

Section 8, D-IV A Environment of Care Management Plan

Policy: Emergency Preparedness Plan

Subject: Cardiopulmonary Arrest, Code Blue

Effective Date: 2-06

Revised: 2-08, 8-11, 3-16

Page 1 of 2

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3-16, 4-16, 3-17, 3-18

IV. CARDIOPULMONARY ARREST – CODE BLUE

POLICY:

- To perform resuscitative measures to re-establish the cardiopulmonary functions on a patient with a cardiac arrest or respiratory arrest.

PROCEDURE:

- A. The anesthesiologist will be primarily responsible for conducting Code Blue. If an anesthesiologist is not available, the physician performing the surgery or procedure will be responsible, as well as ACLS nurses responding to and readily available within the facility. In the event that there is not a physician present, ACLS guidelines will be followed and 911 dispatched.
- B. The receptionist/nursing personnel will:
1. Call **911** at the direction of nursing personnel.
 2. Copy patient chart in preparation for transfer to hospital, by other available personnel.
- C. The nursing personnel will:
1. Verify cardio-pulmonary arrest, note time and alert fellow staff. Call “Code Blue” with location using the overhead paging system. Begin emergency resuscitation procedures (CPR).
 2. Notify patient’s physician and/or on-call physician.
 3. Emergency department or appropriate receiving department of receiving hospital will be notified of impending arrival and physician to physician report provided.
 4. Administer medications as ordered by physician or per ACLS guidelines. SCOR will keep first line emergency ACLS drugs stocked on cart.
 5. Record events on appropriate record sheet.
 6. Oversee activity of code.
 7. Assign personnel to care for family and other patients.
 8. Draw any blood work requested.
 9. Manage patient care until 911 arrives or resolution of code as determined by physician responsible for the code.
 10. Give report and copies of patient chart to ambulance personnel. Complete the consent to transfer form and attach any Advance Directives if available.
 11. Check equipment and replace stock used after code (see crash cart contents)
- D. Surgical Technicians will assist as directed and assigned by nursing personnel (i.e., runners for supplies).

SURGERY CENTER OF RENO

Section 8, D-IV A Environment of Care Management Plan

Policy: Emergency Preparedness Plan

Subject: Cardiopulmonary Arrest, Code Blue

Effective Date: 2-06

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Page 2 of 2

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- E. In most instances it is a PACU nurse who is responsible to bring the crash cart in the event of Code Blue being called. The crash cart is to be taken to the site where the code is called. Additional nursing staff will remain with other patient's.
 - F. Signs shall be posted at all patients entrances, indicating the *Surgery Center of Reno* is not equipped to handle, and therefore does not provide emergency assistance. If persons from the community present themselves to SCOR requiring emergency services, staff will administer appropriate temporary emergency treatment and BLS to stabilize the patient and will IMMEDIATELY call "911" for the appropriate emergency response team. The Nurse/staff member will complete any required forms and a Facility Occurrence Report. All documentation will be forwarded to the Administrator.

Who Should Know This Policy

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| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |

The following positions are responsible for the accuracy of the information contained in this document:

- Governing Body Administrator Medical Director Clinical Managers
 Director of Nursing

SURGERY CENTER OF RENO

Section 8, D-IV B.2 Environment of Care Management Plan

Policy: Emergency Preparedness Plan

Subject: Bomb Threat, Code Black

Effective Date: 2-06

Revised: 6-08, 8-11

Page 1 of 2

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,
3-16, 3-17, 3-18

IV.B.2 BOMB THREAT –Code Black

POLICY:

- A bomb threat against SCOR may be received at any time by phone, mail or message. Any employee receiving a telephone bomb threat will make every effort to follow the procedure outlined below.

PROCEDURE:

Any employee receiving a bomb threat call will follow procedure A and B as outlined below:

A. Employee receiving the call will:

1. Make every effort to obtain detailed information from the caller using the *SCOR's Bomb Threat Checklist* as a guide.
2. Notify the Administrator immediately if he/she is in SCOR; otherwise notify the next person in the chain of command.
3. Dial *911* and notify the local authorities. Answer all questions and stay on the line until they tell you to hang up.
4. Once you are off the phone with the authorities, immediately relay any instructions to the Administrator or person in charge.
5. Call Welltower to notify the other building occupants at 916-682-4495 or after hours service at 866-568-5855.

B. Administrator or Acting Person in Charge will:

1. While the employee is on the phone with local authorities, notify the Medical Director of the bomb threat.
2. Make plans to evacuate or when advised by the police and/or fire department.
3. Announce over the intercom three (3) times; "*CODE BLACK*".
4. Notify Physicians in the surgery suite of situation. The surgeon and anesthesiologist will determine timeliness of evacuation for any patient under anesthesia.

C. All Personnel:

1. Those employees involved with patient care will remain with the patient. All others will perform a spot check in their area for unidentified packages and report to the department manager for further instructions.
2. Follow evacuation plan. All visitors and ambulatory patients will be evacuated to the safe zone.

D. Following the evacuation:

1. Administrator and Medical Director will:
 - a) Make a coordinated decision whether to search the grounds.
 - b) Organize a search of the Surgical Center if appropriate.

SURGERY CENTER OF RENO

Section 8, D-IV B.2 Environment of Care Management Plan

Policy: Emergency Preparedness Plan

Subject: Bomb Threat, Code Black

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Page 2 of 2

**Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,
3-16, 3-17, 3-18**

- c) Cooperate with all agencies present.

 - d) All Employees will if any suspicious object, package or container is found, **DO NOT TOUCH OR MOVE IT**. The Administrator, who will call “911”, will notify all personnel immediately so they may evacuate the building and the Administrator so he/she can notify the local authorities.
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Who Should Know This Policy

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| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |

The following positions are responsible for the accuracy of the information contained in this document:

- Governing Body Administrator Medical Director Clinical Managers
 Director of Nursing

SURGERY CENTER OF RENO

Section 8, D-IV B.3. Environment of Care Management Plan

Policy: Emergency Preparedness Plan

Subject: Earthquake, flood, heat wave, thunderstorms, Code Grey

Effective Date: 2-06

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Page 1 of 4

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,
3-16, 3-17, 3-18

IV. B.3. EARTHQUAKE, FLOOD, HEAT WAVE, THUNDERSTORMS – Code Grey

POLICY:

- Natural disasters can be a serious threat to the safety of SCOR facility and to all persons present, during its occurrence. The SCOR'S staff will be prepared to handle the situation and safely care for patients and for each other in accordance with the following procedures.

PROCEDURE:

The Administrator, Director/Clinical Manager, and the Safety Officer and their designated help will coordinate the activities during internal disasters in order to maintain and promote an organized, safe, and calm situation. HAVBED will be updated in the event of a community wide disaster with available resources. In the event of an internal disaster, HAVBED can be accessed to notify the community and State of Nevada via web address:

<https://www4.emsystem.com/EMSystem>. As part of the IHCC, the Administrator or Director of Nursing will notify the Washoe County Emergency Management team for instructions during a disaster (see attached Washoe County Health District contact list).

I. Earthquake: Because there is usually no warning and earthquakes can occur suddenly, staff must protect themselves and patients.

A. During the earthquake:

1. Stay where you are -- don't run indoors or outdoors.

a) If you are indoors:

- (1) Stay near the center of the building, in hallways, or in a doorway. Choose a location which will allow you air to breathe in the event the building collapses around you.
- (2) If you are near the outer perimeter of building, get away from windows and under desk, table, or heavy, sturdy furniture. Be prepared to hold onto these sturdy items and move with it during the earthquake.
- (3) Stay away from windows, shelving, or areas where objects might fall from the ceiling or walls.
- (4) Stay calm.
- (5) Since SCOR is on the first floor, the staff can expect the fire alarms and sprinklers may go off during a quake.

b) If you are outdoors:

- (1) Stay away from buildings, power lines, towers, poles, trees, etc.
- (2) Lie flat on the ground until shaking stops.
- (3) Remain in a clear area and do not enter buildings until they are inspected and declared safe to enter.

SURGERY CENTER OF RENO

Section 8, D-IV B.3. Environment of Care Management Plan

Policy: Emergency Preparedness Plan

Subject: Earthquake, flood, heat wave, thunderstorms, Code Grey

Effective Date: 2-06

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Page 2 of 4

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,
3-16, 3-17, 3-18

- (4) Don't use open flames until you are advised that is safe to do so.
- (5) Stay calm.
2. Staff should protect patients:
 - a) Keep patients calm and prevent hysteria.
 - b) Instruct ambulatory patients to move as little as possible to a nearby safe place - stand in hallways near center of building or in a doorway and away from windows.
 - c) If patients unable to get out of gurneys, pull privacy curtains around beds and either pull covers completely over themselves (including face and head) to protect from flying glass and objects. Both staff and patients should protect their eyes by pressing their faces against their arm.
 - c) For patients in the O.R. staff will cover any open incisions with a sterile towel or sheet until quake has ceased.
 - d) At that time the O.R. team will evaluate status of facility to determine safety in continuing procedure. All attempts will be made to close as soon as possible.
 - e) The O.R. staff will remain in the O.R. suite with their team until evaluation and determination has been given by one of those 3 people in charge (the Safety Officer, Clinical Manager, or Administrator) will report to each O.R. room to give instructions on how to proceed.
 - f) In the event the facility/situation is deemed unstable the staff and surgeon will close the patient and begin waking patient.
- B. After an earthquake:
 1. Immediately check for injuries. Staff are to check themselves for injuries and check patients for injuries.
 2. Give first aid for serious injuries. If necessary, transfer staff or patients to the hospital for life threatening emergencies. Look for and extinguish small fires. Eliminate fire hazards.
 3. Listen for alerts and/or instructions via cellular phones, if available.
 4. Expect after shocks. Every time a shock is felt, follow procedures for an active earthquake.
- C. Take aftershock precautions for at least seventy-two (72) hours:
 1. Keep all privacy curtains closed around all beds (unoccupied as well as occupied).
 2. Remove all loose objects from shelving, walls, sills, etc. in all patient areas of the building.
 3. Restrict patient and visitor movements to areas where precautions are being enforced.
- D. Inspect facilities and prevent further damage:
 1. Check utility connections for damage or leaks. Repair essential utilities if possible.

SURGERY CENTER OF RENO

Section 8, D-IV B.3. Environment of Care Management Plan

Policy: Emergency Preparedness Plan

Subject: Earthquake, flood, heat wave, thunderstorms, Code Grey

Effective Date: 2-06

Revised: 6-08, 8-11

Page 3 of 4

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,
3-16, 3-17, 3-18

- Secure and tag all non-essential utilities.
 2. Take steps to restore essential services, if necessary.
 3. Establish communication channels with authorities and advise of:
 - a) Numbers and types of casualties, internally.
 - b) Extent of damage to SCOR's facilities.
 - c) Determine possible options for the most efficient use of available facilities and services in the open.
 4. Inspect SCOR to determine if evacuation of patients and staff is necessary.
 5. Minimize required traveling and transport needs.
- E. Reduce post-quake environmental hazards:
1. Secure areas in or around building which pose a danger to pedestrians because of falling objects or other damage.

II. Floods:

- A. When a Flood Watch is issued and it affects the SCOR:
1. Be alert to signs of flash flooding
 2. Listen to local radio and TV stations for information and advice.
- B. When a Flood Warning is issued:
1. Be prepared to evacuate staff and patients if evacuation for the area is issued by the State Emergency System. Depending on the progress of the surgery or procedure, the physician will abort or complete the on-going surgery or procedure. All patients in PACU will be recovered until the discharge criteria has been met and the patient can safely be discharged. All remaining surgeries or procedures will be cancelled.

III. Heat Wave:

- A. If the State Emergency System issues a heat wave advisory, the occupants of the SCOR will be warned of the Advisory and are instructed on safety measures when leaving the SCOR. Water and non caffeinated fluids are offered to occupants as they leave.
- B. Window coverings in the SCOR will be drawn to help decrease the penetration of the heat into the facility.

IV. Thunderstorms:

- A. During a thunderstorm, the occupants are encouraged to remain in the SCOR until it is safe to leave SCOR. Move occupants away from windows.

SURGERY CENTER OF RENO

Section 8, D-IV B.3. Environment of Care Management Plan

Policy: Emergency Preparedness Plan

Subject: Earthquake, flood, heat wave, thunderstorms, Code Grey

Effective Date: 2-06

Revised: 6-08, 8-11

Page 4 of 4

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,
3-16, 3-17, 3-18

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- B. Unused and unnecessary equipment will be unplugged. Avoid using the telephone, including cell phones, unless absolutely necessary. Avoid using electrical appliances.
 - C. Electrical lights will remain on and does not increase the chances lighting striking the SCOR.
 - D. Avoid running water for any unnecessary activity.
 - E. Draw the blinds or shades over the windows of SCOR to help contain glass if it shattered by the thunderstorm.
 - F. If occupants of the SCOR must leave the SCOR, instruct them to call their significant other to notify them of their departure. Instruct occupants leaving the SCOR to call SCOR if they are stuck or stranded if they are unable to contact their significant other and for them to stay in their vehicle until help arrives.

Who Should Know This Policy

- | | | |
|--|--|---|
| <input type="checkbox"/> Pre-Op Staff | <input checked="" type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Clinical Managers |
| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |

The following positions are responsible for the accuracy of the information contained in this document:

- Governing Body Administrator Medical Director Clinical Managers
- Director of Nursing

SURGERY CENTER OF RENO

Section 8, D-IV. B.4

Policy: Facilities and Environment

Subject: Emergency Preparedness –Malignant Hyperthermia

Effective Date: 2-06

Revised: 2-08

Page 1 of 3

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18

D-IV.B.4 MALIGNANT HYPERTHERMIA – Code MH

POLICY:

The following techniques are used to prevent, define, reverse, and manage fulminant hypermetabolism of skeletal muscles, Malignant Hyperthermia (MH). All clinical personnel will be knowledgeable of the procedure for the treatment of malignant hyperthermia so immediate, appropriate action may be initiated in the event of an episode. A Malignant Hyperthermia in-service training with a mock malignant hyperthermia drill is performed yearly at minimum. The decision to allow surgery on known malignant hyperthermia susceptible patients will be on a case-by-case basis per the direction of the Medical Director, attending Anesthesiologist, and Surgeon and will proceed only without the utilization of agents known to trigger MH.

The SCOR's clinical staff will be aware of the causative drug agents that trigger MH and are not safe for patients susceptible to Malignant Hyperthermia:

1. Inhaled general anesthetics: Desflurane, enflurane, halothane, isoflurane, methoxyflurane, sevoflurane, trichloroethylene, Xenon (rarely used).
2. Depolarizing muscle relaxants trigger MH (i.e. succinylcholine).

PROCEDURES:

A. Treating the known or suspected MH-SUSCEPTIBLE patient.

1. Anesthesia machine: Ensure that anesthetic vaporizers are disabled by removing or taping in the "OFF" position.
2. Change CO₂ absorbent (soda lime).
3. Flow 15L/m O₂ or air through new circuit via the ventilator for at least 30 minutes.
4. A new disposable breathing bag will be attached to the Y-piece of the circle system and the ventilator set to inflate the bag periodically.
5. A new disposable breathing circuit will be used.
6. The expired gas analyzer will indicate absence of volatile agents in the anesthesia circuit.
7. The MH cart will be immediately available.

B. Patient with MH Crisis

1. Malignant hyperthermia is life threatening and time is of the essence. Upon first indication, with the orders of the physician in charge of this crisis, call MH HOTLINE 1-800-644-9737 and 911.

2. The SCOR keeps 36 vials of Dantrolene on hand for the purposes of treating malignant hyperthermia. The patient will be transferred once the malignant hyperthermia treatment has been initiated and the patient has been stabilized.

C. Responsibility

1. Anesthesiologist: Team Leader: direct diagnosis, treatment, and transfer
2. Surgeon: manage wound closure as soon as possible
3. Scrub: assist surgeon until wound is closed, then assist team
4. Circulator:
 - a. Call out for help, over head page "Code MH in OR # __" (# of OR crisis is taking place). If a MH drill is taking place state "Mock Code MH in OR # __" Repeat page three times.
 - b. When PACU nurse arrives, OR personnel will change anesthesia circuit and sodasorb, and place temperature monitor.
 - c. Start mixing Dantrolene: all available nurses will report to the OR to assist with mixing Dantrolene.

SURGERY CENTER OF RENO

Section 8, D-IV. B.4

Policy: Facilities and Environment

Subject: Emergency Preparedness –Malignant Hyperthermia

Effective Date: 2-06

Revised: 2-08

Page 2 of 3

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18

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- d. Document events on MH documentation record until a second licensed nurse arrives, then reassign documentation to him/her.
 - e. Circulator or available nurse to call MH Hotline for additional management advice as instructed by the anesthesiologist.
5. PACU Nurse:
 - a. Retrieve Crash Cart and MH cart (if not already present)
 - b. Designate/delegate duties according to color coded assignment cards:
White cards= non clinical staff and Pink cards= licensed clinical staff.
 - c. Assist in mixing Dantrolene.
 - d. Start cooling measures (ice to groin and axilla, cold IVs, cold saline irrigation-provide cold saline to anesthesiologist for nasal gastric irrigation). **DO NOT OVERCOOL** (stop active cooling measures when patient reaches a core temp of 38°C or 100.4°F.)
 6. OR personnel or designee
 - a. Call Administrator and Director/Clinical Managers for additional help in OR.
 - b. OR cases in progress will proceed if an MH crisis is in progress, but no further cases will be started until after the MH crisis has stabilized.
 - c. Assist in making ice packs; bring bags of ice from lounge freezer; check with circulator and, if necessary, obtain more bags of ice as instructed.
 - d. Call 911 as instructed by the anesthesiologist when transfer arrangements have been completed.
 7. The licensed nurse will follow transfer policy and copy chart appropriately.
 8. An Occurrence Report is to be filled out in the event of an MH episode.
 9. A meeting will be scheduled by Nursing Leadership including those present during MH episode to critique and evaluate the response.
- D. Equipment
1. Malignant hyperthermia cart; see list for inventory, retrieve cold Saline solutions from PACU MH refrigerator and ice.
- E. Signs and Symptoms
1. Unanticipated doubling or tripling of end-tidal carbon dioxide.
 2. Skeletal muscle rigidity (even in presence of neuromuscular blockage).
*NOTE: Masseter muscle spasm after use of Succinylcholine may be associated with malignant hyperthermia.
 3. Tachypnea, tachycardia, unstable blood pressure, cyanosis
 4. Hypoxemia
 5. Myoglobinuria (cola-colored urine)
 6. Increased temperature, fever (may be a late sign)
- F. Treatment
1. As outlined in Emergency Treatment for Malignant Hyperthermia (See below)
 2. Documentation: On-going documentation will be completed by an RN
General Outline of Emergency Treatment for Malignant Hyperthermia

PROCEDURE: Acute Phase

1. Notify the Surgeon
 - Discontinue all volatile agents and Succinylcholine.

SURGERY CENTER OF RENO

Section 8, D-IV. B.4

Policy: Facilities and Environment

Subject: Emergency Preparedness –Malignant Hyperthermia

Effective Date: 2-06

Revised: 2-08

Page 3 of 3

Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18

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- Hyperventilate with 100% oxygen. Increase O₂ to 10L/minute.
 - Halt the procedure as soon as possible; if emergent, use non-triggers.
 2. Administer Dantrolene Sodium 2.5mg/kg rapidly IV through large bore IV, if possible
 - Repeat until there is control of the signs of MH.
 - Sometimes more than 10mg/kg (up to 30 mg/kg) is necessary.
 - Dissolve the 20 mg in each vial with at least 60 ml sterile preservative free water for injection. Prewarming (not to exceed 38 °C) the sterile water will speed solubilization of Dantrolene. The crystals also contain NaOH for a pH of 9; each 20 mg bottle has 3 Gm Mannitol for isotonicity.
 3. Administer Sodium Bicarbonate for metabolic acidosis (1-2 mEq/kg IV if blood gas values are not available.
 4. Cool the patient with core temperature greater than 39 ° C (102.2°F). Lavage open body cavities, stomach, or bladder. Apply ice to surface. Infuse cold saline intravenously. Stop cooling if temperature is less than 38 ° and falling to prevent drift less than 36 °C.
 5. Dysrhythmias usually respond to the treatment of acidosis and hyperkalemia.
 - Use standard drug therapy except calcium channel blockers, which may cause hyperkalemia or cardiac arrest in the presence of dantrolene.
 6. Hyperkalemia-Treat with hyperventilation, bicarbonate, glucose/insulin, calcium Bicarbonate 1-2 mEq/kg IV.
 - For *pediatric*, 0.1 units insulin/kg and 1ml/kg 25% glucose
 - For *adult*, 10 units Regular Insulin IV and 50 ml 50% glucose.
 - Calcium chloride 10mg/kg or calcium gluconate 10-50 mg/kg for life threatening hyperkalemia.
 - Check/monitor glucose levels and collect blood for labwork as directed by physician running code.
 7. Follow core temperature, urine output and color.
 - Place Foley catheter and monitor urine output (at least 2-3cc/kg/hr).

Reference: Malignant Hyperthermia: A Clinical Practice Protocol, 2008. Technical Report, The Anesthesia Machine and Malignant Hyperthermia, GE Healthcare, 2011

Who Should Know This Policy

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|---|--|---|
| <input type="checkbox"/> Pre-Op Staff | <input checked="" type="checkbox"/> All Employees | <input checked="" type="checkbox"/> Clinical Managers |
| <input type="checkbox"/> Post-Op Staff | <input type="checkbox"/> All Clinical Staff | <input checked="" type="checkbox"/> Medical Director |
| <input type="checkbox"/> PACU Staff | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator |
| <input checked="" type="checkbox"/> Director of Nursing | | |

The following positions are responsible for the accuracy of the information contained in this document:

- Governing Body Administrator Medical Director Clinical Managers Director of Nursing

SURGERY CENTER OF RENO

Section Appendix Medication Management

Policy: Medication Management

Subject: Adverse Drug Reaction

Effective Date: 2-06

**Review / Revision: 2-07, 2-08, 4-09, 3-10, 3-11, 3-12,
3-13, 3-14, 3-15, 3-16, 3-17, 3-18**

Page 1 of 1

POLICY:

All suspected adverse reactions to medications will be reported to the physician responsible for the patient and Clinical Managers. The Consulting Pharmacist and the QI Committee will also be notified of the occurrence.

Definition:

Adverse drug reaction (abbreviated ADR) is a term to describe the unwanted, negative consequences associated with the use of medication(s). ADR is a subset of an adverse incident.

PROCEDURE:

- A. The licensed nurse will verify with the patient any allergies in the PreOp, OR, and PACU area and will document no known allergies (NKA). In the PACU area, the licensed nurse may need to reference the patient’s chart for status of allergies.
 - B. The nurse will notify the responsible or attending physician immediately of any suspected adverse drug reaction(s), and document the event in the patient’s medical record, including but not limited to the signs and symptoms of the reaction. The responsible or attending physician(s) will treat the patient accordingly, to control and/or manage the signs and symptoms of the ADR.
 - C. The nurse will notify the Clinical Manager and submit a completed incident report and an Adverse Drug Reaction Report. The Clinical Manager will complete the FDA Med Form and forward it to the appropriate agency and complete any other process as required by other external regulatory agencies. See Adverse Drug Reaction Report following this policy.
 - D. The Clinical Manager will conduct a thorough investigation and analysis of the adverse drug reaction by auditing the chart, interviewing staff members caring for the patient in regards to medications, and consulting with the attending physician and Consulting pharmacist.
 - E. The Clinical Manager will submit the incident report and the results of the investigation and analysis with potential improvements in processes or systems that would tend to decrease the likelihood of such incidents in the future, or determine that no such improvement opportunities exist to the QI Committee and to the GB.
-

Who Should Know This Policy

- All licensed Nurses
- Clinical Managers
- Medical Director
- Administrator
- Contracted Pharmacist

The following positions are responsible for the accuracy of the information contained in this document:

- Governing Board
- Administrator
- Medical Director
- Clinical Managers
- Contracted Pharmacist
- Director of Nursing

REFERENCE: Appendix: Medication Management: Adverse (drug) reactions – Medicare standard 416.48 (a) (1)

SURGERY CENTER OF RENO

Section: Appendix OSHA

Policy: Bloodborne Pathogens Standard, 29 CFR 1910.1030 (g)(2),

Subject: Bloodborne Pathogens Exposure Plan, Attachment A: Methods of Compliance

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 8-18

Page 1 of 8

Attachment A Methods of Compliance

A. Universal Blood and Body Fluid Precautions:

1. Blood and body fluid precautions will be used by all employees who come in contact with human blood, body fluids or OPIM. OSHA's definition of body fluid is limited to blood, semen, vaginal secretions, breast milk, cerebrospinal, amniotic, pleural, pericardial, synovial, or other fluids that contain visible blood. Recognizing that blood is not always visible in body fluids, or until and exposure has occurred, universal precautions must be used with all blood and body fluids, regardless of the perceived status of the source individual. Health care workers in SCOR will consider all human blood and body fluids as potentially infectious and must use appropriate protective measures to prevent possible exposures.

OSHA mandates that universal blood and body fluid precautions be implemented as part of an exposure control plan (29CFR1910.1030). The Nevada Administrative Code (NAC441A.025) mandates compliance with universal precautions in the healthcare setting as of 1/24/92. The Infection Control Committee, Safety Committee, and the Governing Board have approved the implementation of universal precautions.

B. Engineering and Work Practice Controls:

When possible, engineering and work practice controls will be used to eliminate or decrease employee exposures to Bloodborne pathogens. Where occupational exposure remains after institution of these controls, personal protective equipment will also be used. Examples of these engineering controls at the SCOR are use of Sharps containers, self-sheathing needles, and safer medical devices such as sharps with engineered sharps injury protections. These devices will be used as a first line of defense against bloodborne pathogens exposure.

The SCOR will participate in the evaluation of safety engineered sharp/medical devices. The Director/Clinical Manager and Administrator will coordinate the evaluation, consideration, and implementation of these safety engineered devices. These devices will be updated as necessary to reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens.

Documentation of consideration and implementation of appropriate and effective safer medical devices will be maintained by SCOR.

Interactive training will be provide whenever new engineering and work practice controls are introduced into the work area.

Employees are responsible for direct patient care will participate in the evaluation and selection of safer devices.

SURGERY CENTER OF RENO

Section: Appendix OSHA

Policy: Bloodborne Pathogens Standard, 29 CFR 1910.1030 (g)(2),

Subject: Bloodborne Pathogens Exposure Plan, Attachment A: Methods of Compliance

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 8-18

Page 2 of 8

1. Needle-stick/puncture precautions:
 - a. All employees must take precautions to prevent injuries when using needles, scalpels, scissors, and other sharp instruments/devices during procedures, when cleaning instruments, during disposal of used needles and sharps, and when handling sharp instruments after procedure.
 - b. Needles must not be recapped, sheared, bent, broken, or removed from disposable syringes, or manipulated by hand. EXCEPTION: If the procedure requires that the contaminated needle be recapped for procedures or treatments where the reuse of needle on the same patient occurs. If such action is required, then the recapping or removal of the needle must be by the one-handed technique or a mechanical device.
 - c. Broken or contaminated glassware must be cleaned up with mechanical devices, i.e.: brushes, dust pans, or forceps.
 - d. All disposable syringes, needles, scalpel blades, scissors, slides, and other sharps items are to be placed in puncture resistant containers for disposal.
 - e. Puncture resistant sharps/needle disposal containers are to be leak-proof and are to be located as close as practical to areas where they are used.
 - f. All puncture resistant/needle disposal containers are to be replaced when they are 3/4th full.
2. Handwashing:
 - a. Hands and other skin surfaces must be washed as soon as possible if they become contaminated with blood or body fluids, after gloves or other PPE are removed, and when leaving the work area. The SCOR provides hand-washing facilities to the employees who incur exposure to blood or other potentially infectious materials. These facilities are readily accessible throughout the surgical center and located at the nursing station, the scrub sinks in the surgery corridor, the sterilization area, the clean/decontamination rooms, the employees' lounge, and the employees changing areas and bathroom facilities, and the patient's bathrooms. If a malfunction occurs with the hand washing facilities, the SCOR provides an appropriate antiseptic hand cleanser that doesn't require rinsing with water. The cleanser may be used in conjunction with clean cloth or paper towels. When antiseptic hand cleansers are used, hands will be washed with soap and running water as soon as feasible. The alcohol based cleansers are located at multiple sites throughout the facility.
 - b. The Director/ Clinical Manager and/or Administrator is responsible to ensure that these hand cleansers are available and appropriately mounted.

SURGERY CENTER OF RENO

Section: Appendix OSHA

Policy: Bloodborne Pathogens Standard, 29 CFR 1910.1030 (g)(2),

Subject: Bloodborne Pathogens Exposure Plan, Attachment A: Methods of Compliance

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 8-18

Page 3 of 8

- c. If employees incur exposure of their skin or mucous membranes to blood or other potentially infectious materials, those areas shall be washed or flushed with water as appropriate, as soon as feasible following contact.
3. Work Practice Controls:
- a. In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials or where body fluid specimens are handled, employees are not to eat, drink, smoke, apply cosmetics or lip balm, or handle contact lenses
 - b. Food and drink will not be stored in refrigerators, freezers, shelves, cabinets, or on countertops or bench tops where blood or other potentially infectious materials are present
 - c. All procedures involving blood or other potentially infectious materials will be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.
 - d. Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.
 - e. Specimens of blood or other potentially infectious materials will be placed in a container, which prevents leakage during collection, handling, processing, storage, transport, or shipping. The container used for this purpose will be labeled or color-coded in accordance with the requirements of the OSHA standard. The SCOR does not have any specimens that could puncture a primary container. If the outside of the specimen container becomes contaminated, the container will be placed within a secondary container which prevents leakage during the handling, processing, storage, transport, or shipping of the specimen. Requisition slips will be attached to the outside of the secondary container.
 - f. The surgeon and the assisting scrub technician use extreme caution when passing sharps between each other. In certain surgical procedures, the surgeon may or may not operate under the use of a microscope and is unable to look away to obtain instruments, including sharps, from the scrub technician. Thus, the passing of sharps in a covered state or in a holding container is unsafe in these specific situations. The sharps will be passed to the surgeon by the scrub technician, who will hold the handle of the sharps with the sharp edge pointed down and under his/her hand and never toward the surgeon. The position of the scrub technician's hand will be in the pronated position as the sharp is placed into the surgeon's hand. The scrub technician will then release the sharp after the surgeon obtains the sharp and remove his/her hand down and away from the sharp. The surgeon will pass the sharp back to the scrub technician in the same

SURGERY CENTER OF RENO

Section: Appendix OSHA

Policy: Bloodborne Pathogens Standard, 29 CFR 1910.1030 (g)(2),

Subject: Bloodborne Pathogens Exposure Plan, Attachment A: Methods of Compliance

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 8-18

Page 4 of 8

fashion or may lay the sharps down and verbally communicate “sharp down, blade down, etc.” to inform the scrub technician of the location of the sharp.

g. When moving containers of contaminated sharps from the area of use, the containers will be closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport.

h. Containers that have decontaminated items need not be labeled or color-coded.

4. Laundry:

- a. Soiled linens or reusable protective clothing must be handled as little as possible.
- b. All used laundry will be considered potentially infectious and will be placed in standard laundry bags. Linens soaked with blood or body fluids must be double bagged. PPE will be worn in order to prevent/reduce contact to blood or OPIM.
- c. The SCOR has a contract with a company for linen and laundry service that also practices Universal Precautions. SCOR staff will place contaminated laundry in labeled red bags to communicate the contents of the bags to the laundry service.

5. Environmental Controls:

- a. General housekeeping - SCOR will ensure that the SCOR worksite is maintained in a clean and sanitary condition. Work surfaces are to be decontaminated with an appropriate disinfectant after completion of procedures or as soon as possible when contamination with blood or body fluids and at the end of the day.
- b. Blood or body fluid spills must be decontaminated as soon as possible. Spills should be soaked up with an absorbent material and disinfected with an EPA approved tuberculocidal or microbacterial viral disinfectant. Broken glassware, which may be contaminated, must not be picked up directly with hands. Tools used for cleanup must be decontaminated or disposed. All broken equipment capable of inflicting percutaneous injury must be disposed of in appropriate sharps container.
- c. Protective coverings used to cover surfaces must be removed as soon as possible when contaminated with blood or body fluids and either appropriately decontaminated or disposed.
- d. Contaminated disposable items (disposable gloves, gauze, dressings, etc.) should be placed in a sturdy, leak-proof plastic containers or bags and closed tightly for transport.

SURGERY CENTER OF RENO

Section: Appendix OSHA

Policy: Bloodborne Pathogens Standard, 29 CFR 1910.1030 (g)(2),

Subject: Bloodborne Pathogens Exposure Plan, Attachment A: Methods of Compliance

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 8-18

Page 5 of 8

- e. Blood or body fluids in pleuravacs, blood bags, suction liners, materials dripping or saturated with blood, etc., are regulated waste and must be terminally placed in biohazard boxes.
 - f. Contaminated, reusable equipment must be decontaminated with an EPA approved tuberculocidal or microbacterial viral disinfectant.
 - g. Biohazard signs must be placed on containers of regulated medical waste, containing blood or OPIM and other containers used to store or transport contaminated materials.
 - h. Contaminated Equipment to be serviced: Unless SCOR demonstrates decontamination of the equipment or portions of the equipment is not feasible, equipment which may become contaminated with blood or other potentially infectious materials will be examined prior to servicing or shipping and a readily observable tag or label will be attached to the equipment stating which portions remain contaminated. SCOR will ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, and prior to handling, servicing, or shipping so that appropriate precautions will be taken.
 - i. All buckets, bins, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials will be inspected and decontaminated on a weekly basis and cleaned and decontaminated immediately as soon as feasible upon visible contamination.
6. Personal Protective Equipment (PPE):
- a. Employees must use appropriate PPE and precautions to prevent skin and mucous membrane contact with any blood or any body fluid.
 - b. Training will be provided to each employee as to the appropriate selection, location, use, and disposal of PPE during their clinical orientation.
 - c. The type of PPE available to employees are as follows: Gloves, gowns, masks, goggle, eye shields, foot protection, head protection.
 - d. Each employee is instructed to critically review their work responsibilities to make informed decisions or recommendations regarding appropriate use of PPE.
 - e. When there is an occupational exposure, the SCOR will provide, at no cost to the employee, appropriate personal protective equipment.

SURGERY CENTER OF RENO

Section: Appendix OSHA

Policy: Bloodborne Pathogens Standard, 29 CFR 1910.1030 (g)(2),

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Page 6 of 8

Personal protective equipment will be chosen based on the anticipated exposure to blood or other potentially infectious material. Personal protective equipment will be considered “appropriate” only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee’s surgical attire, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time that the protective equipment is used. The SCOR will ensure that appropriate PPE in the appropriate sizes are readily accessible at the SCOR in the respective changing areas for employees, at the nursing and patient care areas, and in the surgical suites.

1. **Gloves:** Gloves will be worn when it can be reasonably anticipated that the employee may have hand contact with blood, body fluids, or OPIM, mucous membranes, non-intact skin, when performing vascular access procedures, when the employee has cuts, scratches, or other breaks in his or her skin, and when handling or touching contaminated items or surfaces. Wash hands immediately after removing gloves. Never wash or decontaminate disposable gloves for reuse. Replace gloves if torn, punctured, contaminated, or their ability to function as their barriers are compromised.
2. **Masks, Eye Protection, and Face Shields.** Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields, will be worn whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonable anticipated.
3. **Gowns, Aprons, or Other Protective Body Clothing.** Appropriate protective clothing such as, but not limited to, gowns, aprons, clinic jackets, or similar outer garments will be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.
4. **Surgical caps or hood and/or shoe covers** will be worn in instances when gross contamination with blood or body fluids can reasonable be anticipated.
- f. Resuscitation bags or other ventilation devices should be available in areas where resuscitation is anticipated.
- g. Alternative gloves/PPE will be provided to employees who are sensitive or allergic to the gloves normally provided.
- h. All non-disposable PPE will be maintained, cleaned, and disposed of by SCOR.

SURGERY CENTER OF RENO

Section: Appendix OSHA

Policy: Bloodborne Pathogens Standard, 29 CFR 1910.1030 (g)(2),

Subject: Bloodborne Pathogens Exposure Plan, Attachment A: Methods of Compliance

Effective Date: 2-06 Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 8-18

Page 7 of 8

i. Utility gloves will be decontaminated for re-use if the integrity of the glove is not compromised. However, the gloves must be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromise.

j. When personal protective equipment is removed, it will be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

k. All personal protective equipment will be removed prior to leaving the work area.

7. Hepatitis B Vaccination:

Employees with occupational exposures to blood or OPIM must be offered and encouraged to participate in the Hepatitis B vaccination program. This is offered at no cost to the employee designated to have a potential risk of exposure to blood or OPIM.

8. Post Exposure Evaluations:

All blood or body fluid exposures must be reported immediately to the Administrator or clinical supervisor.

1. Post Exposure Evaluation Procedures:

A. First aid. Clean/rinse exposed area.

B. Report incident to supervisor.

C. Supervisor to ask source patient to be tested.

D. Employee to be evaluated and or treated within 2 hour window as recommended by CDC, or as soon as possible by the designated workman compensation health care provider.

E. Post exposure prophylaxis (PEP) will be addressed at the designated health care provider, which the employee is referred to.

F. Evaluations by the designated health care provider at date of injury, 6, 12, 24 weeks or as ordered by the health care provider..

G. The employee will complete related sections of the SCOR's occurrence report and Exposure to blood and body fluid report. The Safety Officer and the Administrator will review and finalize these reports. The report, when completed, will become a confidential health file of the employee, as well as the Annual OSHA 300 Log, and satisfy federal OSHA reporting requirements.

2. Workers compensation steps:

a) Depending on severity of injury:

i) Provide access to care/transportation to hospital or clinic

b) Take a statement from the injured worker and any witnesses

c) Provide injured worker with information on carrier

SURGERY CENTER OF RENO

Section: Appendix OSHA

Policy: Bloodborne Pathogens Standard, 29 CFR 1910.1030 (g)(2),

Subject: Bloodborne Pathogens Exposure Plan, Attachment A: Methods of Compliance

Effective Date: 2-06 Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 8-18

Page 8 of 8

i) The Workers' Compensation Poster should be posted in your break or locker room, along with information on your local Workers' Compensation clinic.

Party handling workers' compensation claims	ZURICH CLAIMS SERVICES
Business Address	P.O. Box 49547 Colorado Springs, CO 80949-9537
Business Phone	800-987-3373
Effective Date	11/17/2017
Termination Date	11/17/2018
Policy Number	WC 005473353-06
Employer's FEIN	770615561

d) Contact MedHQ to file First Report of Injury

e) In case of needle sticks – follow the steps above and your own site safety instructions on Bloodborne Pathogens. Employee expenses are covered by Workers' Compensation and patient expenses for any testing are the responsibility of the ASC.

Who Should Know This Policy

All Employees Clinical Managers Administrator Medical Director

The following positions are responsible for the accuracy of the information contained in this document:

Governing Board Administrator Medical Director Clinical Managers

REFERENCE: Appendix: OSHA, Attachment A, BBPE Control Plan

Date: _____ **Employee Signature:** _____

The above signature verifies review of the OSHA compliance and bloodborne pathogen program policy and associated regulations and that any questions have been answered by SCOR Administration to the satisfaction of the employee.

SURGERY CENTER OF RENO

Policy: Bloodborne Pathogens Standards, 29 CFR 1910.1030 (g)(2)

Subject: Bloodborne Pathogens Exposure Control Plan, Attachment B: Tasks and Procedures

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18

Page 1 of 2

Policy:

SCOR abides by OSHA’s Bloodborne Pathogen Regulations, which include the Exposure Control Plan. The following includes, but is not limited to, tasks and procedures that are performed at SCOR. The SCOR continuously strives to provide a safe work environment for its employees.

Purpose:

To inform staff members regarding the needed personal protective equipment (PPE) for tasks and procedures performed in SCOR.

To practice the control measures as expounded in the BBPE Control Plan to protect employees from exposure to potentially infectious materials.

To provide a safe work environment for the staff members of SCOR.

Task/Procedure	Hand washing	Gloves	Gown	Mask	Eye Protection	Face Protection	Comments
Bedpan, Urinal Emptying	X	X					
Changing visibly soiled or contaminated linen/sheet/uniform	X	X	**				
Circulating in the O.R.	X			X	**	**	
Cleaning patient with incontinence of urine or feces	X	X	**				
Cleaning equipment	X	X		*X			*If required by manufacturer of cleaning solution being used
Cleaning up spills of blood/body substance	X	X	**	**	**	**	
Cleaning surgical instruments	X	X		**	**	**	
Collecting specimen	X	X		**	**	**	
Direct contact with blood/body substance	X	X		**	**	**	
Dressing Change	X	X	X^				^ If infection suspected.
Handling, Infectious or Possibly Infectious Material	X	X	**				

SURGERY CENTER OF RENO

Policy: Bloodborne Pathogens Standards, 29 CFR 1910.1030 (g)(2)

Subject: Bloodborne Pathogens Exposure Control Plan, Attachment B: Tasks and Procedures

Effective Date: 2-06 Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18

Page 2 of 2

Starting/Discontinuing I.V.	X	X					
Intubation, Assisting with Endotracheal/Nasal	X	X		X			
Suctioning, Endotracheal/Nasal/Oral	X	X		**	**	**	

SURGERY CENTER OF RENO

Policy: Bloodborne Pathogens Standards, 29 CFR 1910.1030 (g)(2)

Subject: Bloodborne Pathogens Exposure Control Plan, Attachment C:

Determination of Employee's Exposure Category

Effective Date: 2-06 **Review / Revision:** 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13
3-14, 3-15, 3-16, 3-17, 3-18

Page 1 of 2

Attachment C

Determination of Employee's Exposure Category

The BBPE Control Plan of SCOR requires that each employee receives a determination of exposure according to his/her responsibilities. The SCOR will use the categories of exposure as stated by OSHA as follows: The most appropriate category with the highest possibility of exposure has been determined for you and has been checked as follows:

Category I: Job position, responsibilities, and tasks required of the employee to perform as a condition of employment involve exposure to blood, body fluids or tissues. All procedures or other job related tasks that involve an inherent potential for mucous membrane or skin contact with blood, body fluids or tissues, or a potential for spills or splashes of blood, body fluids or tissues are Category I tasks. The employee is required to use appropriate protective measures according to the task being performed. Category I includes licensed nurses (to include PreOp, Circulating, PACU,) and scrub techs, and central core employees.

Category II: Job position, responsibilities, and tasks required of the employee to perform, as a condition of employment does not involve exposure to blood, body fluids or tissues. However, unplanned Exposure Category I tasks, which involve exposure to blood, body fluids or tissues, may be performed. When this occurs, the employee is required to use appropriate protective measures according to the task being performed. Licensed radiologic technicians may be in this category.

Category III: Job position, responsibilities, and tasks required of the employee to perform as a condition of employment do not involve exposure to blood, body fluids or tissue. Category III includes administrative employees: surgery scheduler, front office, medical records, and the Administrator. When performing administrative responsibilities and not delivering direct patient care, the supervisors of the clinical areas and Administrator are in this category.

SURGERY CENTER OF RENO

Policy: Bloodborne Pathogens Standards, 29 CFR 1910.1030 (g)(2)

Subject: Bloodborne Pathogens Exposure Control Plan, Attachment C:

Determination of Employee's Exposure Category

Effective Date: 2-06

**Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13
3-14, 3-15, 3-16, 3-17, 3-18**

Page 2 of 2

I understand the category and the associated responsibilities as stated above. I agree to practice these responsibilities as part of my job description.

Name of employee (Print), Job Title

Date

Signature of employee

Date

Signature of Director, Clinical Manager or Administrator

Date

SURGERY CENTER OF RENO

Policy: Bloodborne Pathogens Standard, 29 CFR 1910.1030 (g)(2)

Subject: Bloodborne Pathogens Exposure Plan, Attachment D:

Sharps Injury Log

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18

Page 1 of 7

Exposure to Blood/Body Fluids

Employee:
Name, Last: _____ First: _____ Middle: _____

Gender: F M Other Date of Birth: ____/____/____

Work Location: _____

Occupation: _____ If occupation is physician, indicate clinical specialty: _____

Section I – General Exposure Information

1. Date of exposure: ____/____/____

2. Number of hours on duty: _____

3. Time of exposure: _____ AM PM

6. Location where exposure occurred: _____

5. Is exposed person a temp/agency employee? Y N

7. Type of exposure: (Check all that apply)

7a. Percutaneous: Did exposure involve a clean, unused needle or sharp object?

Y N (If No, complete Q8, Q9, Section II and Section V-XI)

7b. Mucous membrane (Complete Q8, Q9, Section III and Section V-XI)

7c. Skin: Was skin intact? Y N Unknown (If No, complete Q8, Q9, Section III & Section V-XI)

7d. Bite (Complete Q9 and Section IV-XI)

8. Type of fluid/tissue involved in exposure: (Check one)

Blood/blood products

Solutions (IV fluid, irrigation, etc.): (Check one)

Visibly bloody

Not visibly bloody

Tissue

Other (specify): _____

Unknown

Body fluids: (Check one)

Visibly bloody

Not visibly bloody

If body fluid, indicate one body fluid type:

Amniotic

Saliva

CSF

Sputum

Pericardial

Tears

Peritoneal

Urine

Pleural

Feces/stool

Semen

Other (Specify): _____

Synovial

Vaginal fluid

9. Body site of exposure: (Check all that apply)

Hand/finger

Eye

Arm

Leg

Foot

Mouth

Nose

Other (specify): _____

Section II – Percutaneous Injury

1. Was the needle or sharp object visibly contaminated with blood prior to exposure? Y N

2. Depth of the injury: (Check one)

- Superficial, surface scratch
- Deep puncture or wound
- Moderate, penetrated skin
- Unknown

3. What needle or sharp object caused the injury (Check one)

Device (select one) Non-device sharp object (specify): _____ Unknown sharp object

Hollow-bore needle

- Arterial blood collection device
- Biopsy needle
- Bone marrow needle
- Hypodermic needle, attached to syringe
- Hypodermic needle, attached to IV tubing
- Unattached hypodermic needle
- IV catheter – central line
- IV catheter – peripheral line
- Huber needle
- Prefilled cartridge syringe
- IV stylet
- Spinal or epidural needle
- Hemodialysis needle
- Dental aspirating syringe w/ needle
- Vacuum tube holder/needle
- Winged-steel (Butterfly™ type) needle
- Hollow-bore needle, type unknown
- Other hollow-bore needle

Suture needle

- Suture needle

Other solid sharps

- Bone cutter
- Bur
- Electrocautery device
- Elevator
- Explorer
- Extraction forceps
- File
- Lancet
- Microtome blade
- Pin
- Razor
- Retractor
- Rod (orthopedic)
- Scaler/curette
- Scalpel blade
- Scissors
- Tenaculum
- Trocar
- Wire

Glass

- Capillary tube
- Blood collection tube
- Medication ampule/vial/bottle
- Pipette
- Slide
- Specimen/test/vacuum tube

Plastic

- Capillary tube
- Blood collection tube
- Specimen/test/vacuum tube

Non-sharp safety device

- Blood culture adapter
- Catheter securement device
- IV delivery system
- Other known device (specify): _____

4. Manufacturer and Model: _____

Exposure to Blood/Body Fluids

Page 3 of 7

5. Did the needle or other sharp object involved in the injury have a safety feature? Y N

5a. If Yes, indicate type of safety feature: (Check one) If No, skip to Q6.

- | | |
|---|--|
| <input type="checkbox"/> Blunable needle, sharp | <input type="checkbox"/> Needle/sharp ejector |
| <input type="checkbox"/> Hinged guard/shield | <input type="checkbox"/> Mylar wrapping/plastic |
| <input type="checkbox"/> Retractable needle/sharp | <input type="checkbox"/> Other safety feature (specify): _____ |
| <input type="checkbox"/> Sliding/gliding guard/shield | <input type="checkbox"/> Unknown safety mechanism |

5b. If the device had a safety feature, when did the injury occur? (Check one)

- | | |
|--|--|
| <input type="checkbox"/> Before activation of the safety feature was appropriate | <input type="checkbox"/> Safety feature failed, after activation |
| <input type="checkbox"/> During activation of the safety feature | <input type="checkbox"/> Safety feature not activated |
| <input type="checkbox"/> Safety feature improperly activated | <input type="checkbox"/> Other (specify): _____ |

6. When did the injury occur? (Check one)

- | | |
|--|---|
| <input type="checkbox"/> Before use of the item | <input type="checkbox"/> During or after disposal |
| <input type="checkbox"/> During use of the item | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> After use of the item before disposal | |

7. For what purpose or activity was the sharp device being used? (Check one)

Obtaining a blood specimen percutaneously

- | | |
|---|--|
| <input type="checkbox"/> Performing phlebotomy | <input type="checkbox"/> Performing a fingerstick |
| <input type="checkbox"/> Performing arterial puncture | <input type="checkbox"/> Other blood-sampling procedure (specify): _____ |

Giving a percutaneous injection

- | | |
|---|--|
| <input type="checkbox"/> Giving an IM injection | <input type="checkbox"/> Placing a skin test (e.g., tuberculin, allergy, etc.) |
| <input type="checkbox"/> Giving a SC injection | |

Performing a line related procedure

- | | |
|--|--|
| <input type="checkbox"/> Inserting or withdrawing a catheter | <input type="checkbox"/> Injecting into a line or port |
| <input type="checkbox"/> Obtaining a blood sample from a central or peripheral I.V. line or port | <input type="checkbox"/> Connecting an I.V. line |

Performing surgery/autopsy/other invasive procedure

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Suturing | <input type="checkbox"/> Palpating/exploring |
| <input type="checkbox"/> Incising | <input type="checkbox"/> Specify procedure: _____ |

Performing a dental procedure

- | | |
|---|--|
| <input type="checkbox"/> Hygiene (prophylaxis) | <input type="checkbox"/> Oral surgery |
| <input type="checkbox"/> Restoration (amalgam composite, crown) | <input type="checkbox"/> Simple extraction |
| <input type="checkbox"/> Root canal | <input type="checkbox"/> Surgical extraction |
| <input type="checkbox"/> Periodontal surgery | |

Handling a specimen

- | | |
|---|--|
| <input type="checkbox"/> Transferring BBF into a specimen container | <input type="checkbox"/> Processing specimen |
|---|--|

Other

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Other diagnostic procedure (e.g., thoracentesis) | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other (specify): _____ | |

Exposure to Blood/Body Fluids

Page 4 of 7

8. What was the activity at the time of injury? (Check one)

- | | |
|--|--|
| <input type="checkbox"/> Cleaning room | <input type="checkbox"/> Collecting/transporting waste |
| <input type="checkbox"/> Decontamination/processing used equipment | <input type="checkbox"/> Disassembling device/equipment |
| <input type="checkbox"/> Handling equipment | <input type="checkbox"/> Opening/breaking glass container (e.g., ampule) |
| <input type="checkbox"/> Performing procedure | <input type="checkbox"/> Placing sharp in container |
| <input type="checkbox"/> Recapping | <input type="checkbox"/> Transferring/passing/receiving device |
| <input type="checkbox"/> Other (specify): _____ | |

9. Who was holding the device at the time the injury occurred? (Check one)

- Exposed person
- Co-worker/other person
- No one, the sharp was an uncontrolled sharp in the environment

10. What happened when the injury occurred? (Check one)

- | | |
|--|---|
| <input type="checkbox"/> Patient moved and jarred device | <input type="checkbox"/> Contact with overfilled/punctured sharps container |
| <input type="checkbox"/> Device slipped | <input type="checkbox"/> Improperly disposed sharp |
| <input type="checkbox"/> Device rebounded | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Sharp was being recapped | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Collided with co-worker or other person | |

Exposure to Blood/Body Fluids

Page 5 of 7

Section III – Mucous Membrane and/or Skin Exposure

1. Estimate the amount of blood/body fluid exposure: (Check one)

- | | |
|--|--|
| <input type="checkbox"/> Small (<1 tsp or 5cc) | <input type="checkbox"/> Large (> ¼ cup or 50cc) |
| <input type="checkbox"/> Moderate (>1 tsp and up to ¼ cup, or 6-50 cc) | <input type="checkbox"/> Unknown |

2. Activity/event when exposure occurred: (Check one)

- | | |
|---|--|
| <input type="checkbox"/> Airway manipulation (e.g., suctioning airway, inducing sputum) | <input type="checkbox"/> Patient spit/coughed/vomited |
| <input type="checkbox"/> Bleeding vessel | <input type="checkbox"/> Phlebotomy |
| <input type="checkbox"/> Changing dressing/wound care | <input type="checkbox"/> Surgical procedure (e.g., all surgical procedures including C-section) |
| <input type="checkbox"/> Cleaning/transporting contaminated equipment | <input type="checkbox"/> Tube placement/removal/manipulation (e.g., chest, endotracheal, NG, rectal, urine catheter) |
| <input type="checkbox"/> Endoscopic procedures | |
| <input type="checkbox"/> IV or arterial line insertion/removal/manipulation | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Irrigation procedures | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Manipulating blood tube/bottle/specimen container | |

3. Barriers used by the worker at the time of exposure: (Check all that apply)

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Face shield | <input type="checkbox"/> Mask/respirator |
| <input type="checkbox"/> Gloves | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Goggles | <input type="checkbox"/> No barriers |
| <input type="checkbox"/> Gown | |

Section IV – Bite

1. Wound description: (Check one)

- | | |
|--|---|
| <input type="checkbox"/> No spontaneous bleeding | <input type="checkbox"/> Tissue avulsed |
| <input type="checkbox"/> Spontaneous bleeding | <input type="checkbox"/> Unknown |

2. Activity/event when exposure occurred: (Check one)

- | | |
|---|---|
| <input type="checkbox"/> During dental procedure | <input type="checkbox"/> Assault by patient |
| <input type="checkbox"/> During oral examination | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Providing oral hygiene | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Providing non-oral care to patient | |

Exposure to Blood/Body Fluids

Page 6 of 7

Note: Section V-IX are required when following the protocols for Exposure Management.

Section V – Source Information

1. Was the source patient known? Y N
2. Was HIV status known at the time of exposure? Y N
3. Check the test results for the source patient (P=positive, N=negative, I=indeterminate, U=unknown, R=refused, NT=not tested)

Hepatitis B	P	N	I	U	R	NT
HBsAg						
HBeAg						
Total anti-HBc						
Anti-HBs						
Hepatitis C						
Anti-HCV EIA						
Anti-HCV supplemental						
PCR-HCV RNA						
HIV						
EIA, ELISA						
Rapid HIV						
Confirmatory test						

Section VI – For HIV Infected Source

1. Stage of disease: (Check one)

<input type="checkbox"/> End-stage AIDS	<input type="checkbox"/> Other symptomatic HIV, not AIDS
<input type="checkbox"/> AIDS	<input type="checkbox"/> HIV infection, no symptoms
<input type="checkbox"/> Acute HIV illness	<input type="checkbox"/> Unknown
2. Is the source patient taking anti-retroviral drugs? Y N U
 - 2a. If yes, indicate drug(s): _____
3. Most recent CD4 count: _____ mm³ Date: ____/____/____ (mo/yr)
4. Viral load: _____ copies/ml _____ undetectable Date: ____/____/____ (mo/yr)

Section VII – Initial Care Given to Healthcare Worker

1. HIV postexposure prophylaxis:

Offered? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	Taken: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U (If Yes, complete PEP form)
---	---
2. HBIG given? Y N U Date administered: ____/____/____
3. Hepatitis B vaccine given: Y N U Date 1st dose administered: ____/____/____
4. Is the HCW pregnant? Y N U
 - 4a. If yes, which trimester? 1 2 3 U

Exposure to Blood/Body Fluids

Section VIII – Baseline Lab Testing

Was baseline testing performed on the HCW? Y N U If Yes, indicate results

Test	Date	Result				Test	Date	Result
		P	N	I	R			
HIV EIA	__/__/__	P	N	I	R	ALT	__/__/__	___ IU/L
HIV Confirmatory	__/__/__	P	N	I	R	Amylase	__/__/__	___ IU/L
Hepatitis C anti-HCV-EIA	__/__/__	P	N	I	R	Blood glucose	__/__/__	___ mmol/L
Hepatitis C anti-HCV-supp	__/__/__	P	N	I	R	Hematocrit	__/__/__	___ %
Hepatitis C PRC HCV RNA	__/__/__	P	N	I		Hemoglobin	__/__/__	___ gm/L
Hepatitis B HBs Ag	__/__/__	P	N	I		Platelets	__/__/__	___ x10 ⁹ /L
Hepatitis B IgM anti-HBc	__/__/__	P	N	I		Blood cells in Urine	__/__/__	___ #/mm ³
Hepatitis B Total anti-HBc	__/__/__	P	N	I		WBC	__/__/__	___ x10 ⁹ /L
Hepatitis B Anti-HBs	__/__/__	___ mIU/mL				Creatinine	__/__/__	___ μmol/L
Result Codes: P=Positive, N=Negative, I=Indeterminate, R=Refused						Other: _____	__/__/__	_____

Section IX – Follow-up

1. Is it recommended that the HCW return for follow-up of this exposure? Y N
 1a. If Yes, will follow-up be performed at this facility? Y N

Section X – Narrative

In the worker's words, how did the injury occur?

Section XI – Prevention

In the worker's words, what could have prevented the injury?

Custom Fields

Label		Label	
_____	__/__/__	_____	__/__/__
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments

SURGERY CENTER OF RENO

Policy: Policy: Bloodborne Pathogens Standard, 29 CRF 1910.1030 (g)(2)

Subject: Bloodborne Pathogens Exposure Plan, Attachment F:

Consent or Declination for Hepatitis B vaccination

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18

Page 1 of 2

Attachment F

INFORMED CONSENT FOR HEPATITIS B VACCINE

I understand the benefits and risks of the vaccination. I understand that vaccination is not mandatory but highly recommended. I understand that the vaccine should not be given to anyone that is immunocompromised, allergic to yeast or any of component of the vaccine, pregnant or nursing mothers unless clearly necessary. Relative contraindications include any serous active infection, severely compromised cardiopulmonary function, or any person to whom a febrile or systemic reaction could cause a serious health risk. I certify that to the best of my knowledge I do not have any of the above listed conditions, have been informed of the potential risks and benefits of the Hepatitis vaccination, and request to receive the vaccination.

I understand that I must have three doses of the vaccine over the next 6 months to confer immunity. I know that there is no absolute guarantee that I will become immune or that I will not have adverse reaction from the vaccine.

I REQUEST THAT THE HEPATITIS B VACCINE BE GIVEN TO ME:

Signature of Employee _____
Date

Department					Witness
Date	Site	Lot	Exp	Given By:	
1 st Dose	_____	_____	_____	_____	_____
2 nd Dose	_____	_____	_____	_____	_____
3 rd Dose	_____	_____	_____	_____	_____

*SITE: #1 = left deltoid #2 right deltoid

#1 Signature of employee: _____
#2 Signature of employee: _____
#3 Signature of employee: _____

SURGERY CENTER OF RENO

Policy: Policy: Bloodborne Pathogens Standard, 29 CRF 1910.1030 (g)(2)

Subject: Bloodborne Pathogens Exposure Plan, Attachment F:

Consent or Declination for Hepatitis B vaccination

Effective Date: 2-06

**Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13,
3-14, 3-15, 3-16, 3-17, 3-18**

Page 2 of 2

DECLINATION

I understand that due to my occupational exposure to blood or OPIM I may be at risk of acquiring Hepatitis B infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I **DECLINE TO RECEIVE THE HEPATITIS B VACCINE** and understand that I may be at risk of acquiring the Hepatitis B Virus, as serious disease. If I change my mind at a later date I will be able to receive the Hepatitis B vaccine at no charge to me.

I decline the Hepatitis B vaccine as I have received the vaccine in the past. I received the vaccine in _____ (year).

Signature of Employee

Date

Witness

Transfer switches shall be subjected to a maintenance and testing program that includes the following:

- Monthly testing and operation
- Annually
- Checking of connections
- Inspection or testing for evidence of overheating and excessive contact erosion
- Removal of dust and dirt.
- Replacement of contacts when required (8.3.5)

Maintenance Requirements Testing

EPSS, Including all appurtenant components, shall be inspected WEEKLY and exercised under load MONTHLY (8.4.1).

A log should be kept of the weekly and monthly checks / exercises.

Sample maintenance logs are available in the contents of the NFPA-110 documents.

Routine Maintenance program shall be over seen by a properly instructed individual (8.4.5).

Maintenance Requirements Monthly Testing

Section 8.4.2) Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods.

- 1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.
- 2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating.
- 3) If the engine cannot be operated until the water temperature and the oil pressure have stabilized and then the test shall be terminated before the 30 minute time period expires.

Maintenance Requirements Annual Load Bank Testing

Section 8.4.2.3 Diesel-powered EPS installation that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at

25% of nameplate rating for 30 minutes, followed by 50% of nameplate for 30 minutes followed by 75% of nameplate for 60 minutes, for a total of 2 continuous hours.

Maintenance Requirement 36 Month Load Bank Testing

Section 8.4.9 Level 1 EPSS shall be tested for the duration of its as-assigned class (see Section 4.2), for at least 4 hours, at least once within every 36 months.

Section 8.4.9.1 The load shall be the EPSS system load running at the of the test. The test shall be initiated by opening all switches or breakers supplying normal power to the EPSS

Maintenance Requirements Time Delays

Load tests of generator shall include complete cold start (8.4.4).

Time Delays should be set as follows:

On start: 1 second minimum

Transfer to emergency: no minimum

Return to normal: 5 minutes minimum

Shutdown: 5 minutes minimum

Transfer switches shall be operated monthly (8.4.6

Maintenance Requirements

Section A-5.6.4.5.1 recommends that lead-acid starting batteries be replaced every 24 to 30 months.

Transfer Time

For any generator serving emergency lighting, the load must be picked up by the generator in less than 10 seconds. See section 7.9.1.2 of the Life Safety Code

Fire Extinguisher

A fire Extinguisher should be kept in close proximity to the generator and should be a type for the hazard. Typically a minimum 3A, 40B, C extinguisher within 30 feet of the generator and in the path of egress

SURGERY CENTER OF RENO
INCIDENT REPORT
CONFIDENTIAL - NOT A PART OF MEDICAL RECORD

PATIENT LABEL _____

BRIEF DESCRIPTION (Attach additional sheet, if needed)

Patient/Family aware of incident?_ Yes ____ No ____

A. LOCATION OF INCIDENT: _____

Type of Incident (Check only one that most applies)

B. FALLS

- Slip/fall Found on floor Other

C. MEDICATION VARIANCE

- Contraindicated Omission of dose Wrong patient MD order variance
 Extra doses Wrong dose Wrong route Wrong site
 Confirmed adverse drug reaction Wrong drug/IV solution Wrong time

D. TREATMENT OR PROCEDURE VARIANCE

- Consent/not Documented Complications following procedure Surgical Count/retained FB
 Consent/Different procedure or site Cancellation - post induction Unscheduled return to OR
 Unplanned transfer to hospital Delayed treatment Inability to complete procedure due to complications
 Not ordered Specimen handling error Received unplanned blood/products
 Omitted Surgical count unresolved Cancellation after admission to pre-op
 Technique Undesired Other _____

E. INFECTION SURGERY CENTER

- Infection/Nosocomial confirmed

F. EQUIPMENT/PRODUCT-RELATED INCIDENT

- Defective Electrical shock Improper use Wrong equipment
 Electrical Problem Equipment unavailable Malfunction Other _____

LOT # _____

EQUIPMENT TYPE: _____ MODEL #: _____

MANUFACTURER: _____ SERIAL #: _____

G. MISCELLANEOUS

- AMA/Elopement Fire/thermal Patient injury Patient /family complaint
 Contraband possession Loss/Theft/damaged property Struck by object
 Exposures/biohazard/chemical Patient abuse Security issues Other _____

H. MEDICAL TREATMENT

- N/A Offered Refused Referred for further TX ER visit post-op

Physician Name: _____

Notified Date: _____ Time: _____

Address: _____

I. NATURE OF INJURY SUSTAINED (Check only one that most applies)

- | | | |
|---|--|--|
| <input type="checkbox"/> Abrasion, bruise, contusion | <input type="checkbox"/> Back injury | <input type="checkbox"/> Skin irritation |
| <input type="checkbox"/> Aggravation/pre-exist. Cond. | <input type="checkbox"/> Electric shock | <input type="checkbox"/> Sprain/strain |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Vascular impairment |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Wound disruption |
| <input type="checkbox"/> Cardiopulmonary arrest | <input type="checkbox"/> IV infiltration/extravasate | <input type="checkbox"/> Unable to determine |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Laceration | <input type="checkbox"/> None/NA |
| <input type="checkbox"/> Contagious disease | <input type="checkbox"/> Neurological impairment | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Death/at facility | <input type="checkbox"/> Pulmonary embolism - DVT | |
| <input type="checkbox"/> Death/ following hospital transfer | <input type="checkbox"/> Puncture | |
| <input type="checkbox"/> Death/ within 72 hours discharge | <input type="checkbox"/> Respiratory impairment | |

J. RELATED FACTORS (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Bowel/bladder problem | <input type="checkbox"/> Refused orders | <input type="checkbox"/> Unexpected movement |
| <input type="checkbox"/> Improper footwear | <input type="checkbox"/> Floor wet/obstructed | <input type="checkbox"/> NA |
| <input type="checkbox"/> Unable to follow orders | <input type="checkbox"/> Safety device used improperly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Seeking attention | <input type="checkbox"/> Employee did not follow procedure | |
| <input type="checkbox"/> Vision impaired | <input type="checkbox"/> Siderails down | |
| <input type="checkbox"/> Horseplay/rowdiness | <input type="checkbox"/> Bed position Hi ___ Lo ___ | |
| <input type="checkbox"/> Medical/surgical condition | <input type="checkbox"/> Safety device not ordered | |
| <input type="checkbox"/> Visitor assisting patient | <input type="checkbox"/> Call light not in reach | |
| <input type="checkbox"/> Language barrier | | |

K SEVERITY LEVEL

- | | | |
|--------------------------|---------|---|
| <input type="checkbox"/> | LEVEL 1 | EVENT IS NOT RELATED TO ILLNESS OR INJURY/NO APPARENT INJURY |
| <input type="checkbox"/> | LEVEL 2 | OCCURRENCE THAT CAUSES TEMPORARY ILLNESS OR INJURY; WHETHER OR NOT PHYSICIAN INTERVENTIONS REQUIRED |
| <input type="checkbox"/> | LEVEL 3 | INJURY WITH POTENTIAL FOR COMPLICATION/FOLLOW UP REQUIRED BY MD |
| <input type="checkbox"/> | LEVEL 4 | MAJOR INJURY; OCCURRENCE IS POTENTIALLY LIFETHREATENING; IMMEDIATE PHYSICIAN INTERVENTIONS REQUIRED |
| <input type="checkbox"/> | LEVEL 5 | OCCURRENCE RESULTING IN DEATH WITHIN 72 HOURS |

WITNESSES

Name: _____ Name: _____

EMPLOYEE PREPARING REPORT

Name _____ Date/Time: _____ Title: _____

L. HOW COULD THIS EVENT HAVE BEEN PREVENTED?

M. Explanation of Investigation/Follow-up/corrective action taken:

Signature: _____ Title: _____

N. This section to be completed by Medical Director/Administration

The above incident has been generated. Please review the incident and indicate what action is required.

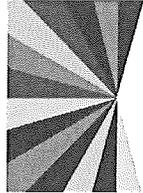
- | | |
|---|--|
| <input type="checkbox"/> No action at this time | <input type="checkbox"/> Discuss in QI |
| <input type="checkbox"/> Physician review | <input type="checkbox"/> Notify Risk Management |
| <input type="checkbox"/> Instruction/Education | Statistics: <input type="checkbox"/> Infection <input type="checkbox"/> Complication |
| <input type="checkbox"/> Action/Recommendation | |

Administrator Signature: _____ Date/Time: _____

Medical Director: _____ Date/Time: _____

Governing Board: _____ Date/Time: _____

Effective as of: _____



Surgery Center
of Reno

Quality Improvement Plan

SURGERY CENTER OF RENO, LLC

Approved by the Medical Staff

By: _____ Dated: _____

Medical Director

Adopted by the Governing Board of Directors

By: _____ Dated: _____

President of the Board

Approved by the Administrator

By: _____ Dated: _____

Surgery Center of Reno

Quality Improvement Plan

Purpose:

This organization provides ongoing monitoring of important aspects of the care provided. Health care professionals participate in the development and application of the criteria used to evaluate the care they provide. The Quality Improvement (QI) program addresses clinical, administrative and cost-of-care issues, as well as actual patient outcomes. Data related to established criteria are collected in an ongoing manner. Collected data are periodically evaluated to identify unacceptable or unexpected trends or occurrences that influence patient outcomes. Information will be gathered, logged and identified on a quarterly basis by the Quality Improvement Committee. This will include the laboratory consultant who will review all logs kept (i.e. blood glucose). The radiology safety officer will monitor the radiation safety issues for the facility including radiation badge levels. The pharmacy consultant will review all pertinent pharmacy data including narcotic review monthly. In addition, the contract service providers may provide appropriate in-service education for the staff of the facility as requested by the facility.

QI Indicators to be monitored will include:

- 1) Patient Satisfaction, Employee Satisfaction, Physician Satisfaction
- 2) Patient Follow-up: a) post op phone calls b) post –op complications
- 3) Post Operative Occurrences
- 4) Medication Use , Pharmacist review, Adverse Reaction Log & Medication Error Log per occurrence reporting system
- 5) Cancellations on Day of Surgery
- 6) Medical Record Review
- 7) Safety
- 8) Infection Control
- 9) Credentials
- 10) Employee Files
- 11) Ancillary Services
- 12) Employee Blood Borne Pathogen Exposures
- 13.) Patient Complications – Transfers, Returns to Surgery,

Quality Improvement Issues:

In addition to the on-going monitoring of QI indicators, staff and department managers will be encouraged to develop and assess “Quality Improvement Issues” to ensure department concerns are addressed and corrected. QI activities are consistent with the characteristics of the organization’s overall QI program. QI activities will follow the five steps of “closing the QI loop”.

Routine monitoring will also include:

Emergency Cart / Defibrillator checks

Refrigerator and Fluid warmer temperature checks.

The Quality Improvement Plan, the Peer Review Plan and Processes and the Risk Management Plan are all integrally inter-related in the overall quality processes of the ASC. When one process is affected all subsequent processes and plans can be affected and may require follow-up and/or evaluation of the quality of care provided and the risks to the facility.

QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN

Las Vegas Surgery Center 2018

The mission of Las Vegas Surgery Center is focused on delivering the highest quality, cost effective healthcare that effectively responds to the needs and safety of our patients by minimizing the possibility for injury or harm to our patients. We are committed to the care, dignity and improvement of human life to the patient populations we serve.

In keeping with the mission of the Las Vegas Surgery Center community, HCA initiatives, and regulatory standards for ambulatory surgical care, this plan allows for a planned, systematic, organization-wide approach to the quality improvement process, and assessing opportunities to reduce risk. This is accomplished through an effective risk and quality program, as well as a medication and radiation safety plan that are all targeted toward improving patient safety. The activities will be carried out in a collaborative and interdisciplinary manner. When identified, individual competency issues and process changes will be coordinated with management team and human resources. The overall strategies of the program include

- Improving patient safety and reducing risk to patients which includes, but not limited to medication and radiation safety, safe quality care and reducing risk of injury to patients and staff;
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety;
- Assuring that quality improvement initiatives continue to focus on high priority areas of clinical care, monitoring of process and outcome indicators; redesigning processes and systems and providing education to foster improvement;
- Positioning the Las Vegas Surgery Center to achieve earning expectations and maintain effective cost-containment strategies while providing high quality of patient care, and
- Meeting the expectations of the HCA internal initiatives, as well as the external regulatory and accrediting bodies through the identification of opportunities to improve patient care, demonstration of appropriate action taken, and follow up on the effectiveness of action taken.

Strategies will be incorporated in each of the following areas to identify opportunities and set goals to achieve and sustain the desired results:

- Performance Improvement Processes
- Quality studies
- Risk Management Strategies
- Patient Safety Initiatives
- Infection Control Strategies
- Medication Safety Strategies
- Radiation Safety Initiatives

HCA Patient Safety Organization (PSO), LLC

HCA established a Patient Safety Organization, LLC in spring of 2014 in accordance with provisions of the Patient Safety and Quality Improvement Act (Public Law 109-41). The PSO is a component of its parent entity, HCA. The mission of the PSO is to conduct activities to improve patient safety and the quality of healthcare delivery. The vision is to assist participating providers in the elimination of preventable patient harm. The activities of the organization include:

- Improve patient safety and the quality of health care delivery
- Collect and analyze Patient Safety Work Product (PSWP)

- Develop and disseminate information regarding patient safety
- Utilize PSWP to encourage a culture of safety and provide assistance to effectively minimize patient risk
- Maintain procedures to preserve confidentiality and provide appropriate security of PSWP
- Utilize qualified medical personnel
- Operate a patient safety evaluation system (PSES) and provide feedback to participants of the PSO
- Utilizing the Serious Event Analysis (SEA) process to identify the root causes of adverse events

In early 2016 Las Vegas Surgery Center will begin to participate as a member of the HCA Patient Safety Organization (PSO), LLC. The Administrator will serve as the designated PSO Contact and oversees all activities of the PSO for the center. The Risk/Quality Manager shall serve as the Contact Designee, and the Administrator shall serve as the alternative. The Center will provide patient safety work products (PSWP) documents as requested by the PSO. The center will receive information from the PSES to evaluate opportunities for improving patient safety and quality care. All information submitted will remain confidential within the PSO.

Quality Improvement Plan

The Center maintains an ongoing quality improvement program that has a broad scope to address administrative, clinical, and cost effective performance. The program also addresses patient outcomes, patient care processes, as well as medication, radiation and patient safety. Elements of the program include, but are not limited to a:

- Written plan that addresses the scope of health care services provided by the Center and how the quality improvement plan for these services is assessed
- Interdisciplinary QI committee for the development, implementation, review and oversight of the program. The committee has administrative, clinical and physician participation
- Set of goals and objectives that are reviewed and updated at least annually
- Quality improvement activities such as audits and studies to identify problems with processes or patient care, evaluate them, and develop action plans when indicated. The studies will be done utilizing the ten (10) step process that is current practice in quality performance improvement
- Measurement of data against internal and external benchmarking sources
- Annual reviews of the effectiveness of the program
- Periodic reports to Governing Body that encompasses a summary of the quality improvement activities, findings and process changes if indicated

Risk Management and Patient Safety

Definitions of Potential Risk Issues:

Event: A discrete, auditable and clearly defined occurrence (NQF)

Occurrence: The action, fact, or instance of something that happens synonymous with an event; An event, situation, or process that contributes to, or has the potential to contribute to, a patient or visitor injury, or degrade our ability to provide optimal patient care. Reportable occurrences can generally be divided into the following types based on severity: Sentinel events, patient and visitor injuries, [adverse events], near misses (close calls, good catches), and safety concerns.(NPSF)

Incident: Synonymous with occurrence or event. An occurrence or event that interrupts normal procedure and can precipitate an untoward or unplanned outcome, or an unusual event that occurs at the facility, such as an injury to a patient. Involved damage that is limited to parts of a unit, whether the failure disrupts the system or not. (NPSF). A patient safety event that reached the patient, whether or not the patient was harmed (NQF).

Adverse Event: Any deviation from usual medical care that causes an injury to the patient or poses a risk of harm. Events include errors, preventable adverse events, and hazards. An incident in which a patient is harmed (WHO). An injury or the risk thereof caused by medical management rather than the underlying disease. An untoward, undesirable, and usually unanticipated occurrence. An act of commission or omission arising during clinical care which causes physical or psychological injury to a patient regardless of severity, (NQF & NPSF). Any injury caused by medical care. An adverse event does not imply "error," "negligence," or poor quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process (AHRQ). Adverse events may be preventable or non-preventable (WHO).

Serious Preventable Adverse Events (SPAEE) / Sentinel event: A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and results in any of the following (HCA policy definition):

- Death
- Permanent harm
- Severe temporary harm

In the ambulatory surgical setting, an event is also considered sentinel if it is one of the following:

- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient, leading to death, permanent harm, or severe temporary harm to the patient
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care

Close Call / Near Misses / Good Catches: Events or situations that could have resulted in an adverse event (accident, injury, or illness), but did not, whether by chance or through timely intervention. Such events have also been referred to as "near miss" incidents. An example of a close call would be a surgery or other procedure almost performed on the wrong patient due to lapses in verification of patient identification, but caught prior to the procedure (Source: VA Patient Safety Program).

Reportable Event: Any event that is mandated to report by regulatory agencies or corporate within defined time frame. (HCA, CMS, FDA, SMDA, and/or local /state agencies).

Serious Event Analysis (SEA): A method of problem solving that tries to identify the root causes of faults or problems. The SEA process evaluates the underlying "why's" for the variance and solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing on the correction on root causes, problem recurrence can be prevented. An analysis is done *after* an event has occurred. All staff members involved, as well as, the Risk Manager, physicians involved shall participate in the SEA analysis. The SEA process is typically used as a reactive method of identifying event(s) causes, revealing problems and identifying opportunities to reduce the risk of future occurrences. The SEA action plan is reported at the quality meetings, MEC and GB meetings. In 2016 the ASD will be move toward an online program for analysis of serious events called Serious Event Analysis (SEA).

Risk Management: The Center maintains an ongoing risk management program that is designed to protect the life, safety and welfare of the patients and employees. Risk management addresses strategies from the organizational, operational, human resource and liability areas of the organization. Goals of the program include:

- Improving patient safety and reducing risk to patients
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety
- Reviewing and tracking of all variance reports and litigations for trends
- Reviewing and tracking of all adverse outcomes, near misses (close calls) or sentinel events to identify gaps or opportunities for improvement
- Maintaining a strong credentialing and privileging process and current bylaws that meet community standards
- Keeping abreast of current standards for risk management and adapting practice and policies that are compliant with standards

It is evident through the goals, activities and processes that the quality improvement and risk management programs intertwine and cross all spectrums of the organization. Quality care, as well as patient and employee safety is at the center focus of both programs. The operational linkage between Risk management, Safety, Quality and Infection Control is accomplished through the following mechanisms:

- Issues or trends identified through chart reviews, peer reviews, safety, radiation and infection control rounds are discussed and referred to the appropriate department for evaluation and/or corrective action
- Data from variances, identified trends, adverse events or any events that impact the quality or safety of patient care will be reviewed and referred to appropriate risk and leadership personnel for investigation, analysis and corrective action
- The Risk Manager will review current issues and risk reduction strategies with appropriate personnel and develop a plan of action. This action plan will be reported to MEC/GB.
- The Quality Committee will serve as the oversight committee for Patient Safety and Risk management. Medication Safety and Radiation Safety fall within a subsection of the Quality Committee and will be addressed as indicated.

These plans engage active involvement of all members of the healthcare team, as well as patients, families and physicians, addressing an environment which:

- Encourages recognition and acknowledgment of opportunities to improve quality performance and to reduce risks to patient safety
- Initiates actions to improve processes or reduce these risks
- Encourages internal reporting of what has been found and the actions taken
- Focuses on processes and system
- Minimizes individual blame or retribution for involvement in a medical/health care error; and
- Challenges leaders of the organization to be responsible for fostering a "non punitive" culture of continuous improvement, reducing risk, and creating a safe environment for patients, employees and physicians.

Medication Safety: The Regional HCA Pharmacist oversees the medication practices and processes at the center. Their duties include, but not limited to:

- Conducting medication rounds and audits providing feedback on areas of opportunities. This includes validation of safety medication practices
- Collaborating with the center on choice of pharmaceutical vendors and formularies
- Collaborating with the center on policy review and development
- Participating in review of any medication error or diversion
- Assuring controlled substance ordering and monitoring is in accordance to state and federal regulations

All relevant activities are reported through QI/MEC/GB committees

Radiation Safety: This facility utilizes radiation emitting equipment and therefore, by direction of the Governing Body/Board. Radiation Safety will be a subgroup of representatives will be included under the QI/Safety/Risk committee to report radiation safety activities. Key activities are established by the Radiation Right policies identified as CSG.MI.001 Governance and CSG.MI.003 Fluoroscopy:

- Designate an individual that is approved by MEC/GB to oversee the program
- Oversee ongoing measurement, periodic review, and improvement of key radiation safety practices and provide a quarterly report to the QI/Risk/Safety committee
- Periodic maintenance of equipment
- Maintaining exposure time logs
- Communicate relevant radiation safety activities, as necessary, to the staff.
- Serve as a resource for radiation safety as it relates to staff and patient safety/regulatory issues and for the regulatory component of accrediting agencies.
- Educate staff on radiation safety practices

Infection Control: The center conducts an annual infection control risk assessment (ICRA) to identify areas of opportunities to reduce the risk of infections. The ICRA is completed annually and reviewed annually by QI/MEC/GB. (See Infection Control Plan) All infection control activities are reported through QI/MEC/GB.

Peer Review: Ambulatory Surgery Centers are required by AAAHC, CMS, and other regulatory agencies to conduct quality improvement and peer review on Medical Staff and Dependent Healthcare Practitioners (DHP). Peer review activities include ongoing random review, specialty specific review and review of events / complications. Whenever possible, peer review is done by a physician of like specialty.

Whenever possible to avoid conflict of interest, peer review cases will be referred to physicians who are not affiliated with the practitioner being reviewed, and no physician will review a patient's care in which she/he has been professionally involved. Provisions are made to have cases evaluated by an outside expert when necessary.

Confidentiality: All quality improvement and peer review activities and data are considered confidential. Any requests for outside sources for any QI, Risk management, Peer Review or credentialing information or reports will be forwarded to the appropriate HCA administrative/corporate staff when indicated.

ORGANIZATION STRUCTURE AND PROCEDURE

Role of Leadership: Leaders play a key role in facilitating improvement and ensuring a safe environment. The Las Vegas Surgery Center leadership includes the Governing Body, Medical Executive Committee; the facility based Medical Directors, Administrators, Risk/Quality/Safety/Infection Control designees and Clinical Managers. Leaders foster quality improvement through planning, educating, setting priorities, providing support such as time and resources, and empowering staff as appropriate.

Governing Board/Medical Executive Committee: The Board has the ultimate authority and accountability for the quality and risk programs to ensure that the quality of patient care is provided in an efficient, timely and cost-effective manner. The Governing Body provides support for the improvement strategies and delegates to the Medical Executive Committee and leaderships at each facility, the authority to perform assessment and improvement activities through committees and teams. Quarterly, the Governing Body shall receive a report on the activities of the quality and risk management programs.

These functions include, but not limited too:

- Assure QI/Risk/Radiation/Medication/Patient Safety is an integral part of the Center's objectives, plans and management structure
- Provide resources to support the QI/Risk/Patient Safety programs.
- Assure that improvements are sustained and evaluated for effectiveness

- Review and approve policies, reports, QI/Risk/Safety/IFC data collection and analysis, the QI/Risk/Patient Safety plans and annual evaluation.

Administration: The facility Administrators are responsible for providing qualified personnel to support the proper functioning of quality improvement and risk management activities. Administration will participate in performance improvement activities and in the assignment of priorities to the functions identified by performance improvement activities.

Key Goals:

- Assure patient care is delivered safely
- Ensure the ongoing competencies of the staff
- Support an environment that promotes process improvement, quality outcomes, reduction in risk, patient and employee safety and customer satisfaction
- Oversee reviewing and keeping current with regulatory standards (CMS,CDC, state and AAAHC)

Key Activities:

- Develop specific goals, objectives, and targets for quality improvement, risk management, infection control and radiation/medication/patient safety
- Designate responsibility to qualified individuals or an interdisciplinary committee for ensuring that quality and risk goals/objectives, as well as patient safety are achieved
- Provide adequate time and training, as well as resources, for personnel to participate in quality improvement activities and to improve patient safety
- Assure clear systems and policies/procedures for internal and external reporting of information relating to performance indicators/measures and medical/health care errors are designed
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors. Actively encouraging all staff to identify and report hazardous conditions and errors in a blame-free environment
- Establish or supporting changes in processes, functions and services to sustain improved performance and to prevent recurrence and reduce risk to patients
- Assure the effectiveness of the quality and risk management goals/objectives and contributions to improving patient safety are measured and assessed annually

Quality Improvement/ Risk/Infection Control/Patient Safety Committee: Each facility has a quality improvement committee which derives goals from the Governing Body, Medical Executive Committee, Administration, staff and other sources. Primary responsibility of this committee is to maintain a culture of patient safety throughout all patient care processes and organizational functions. This committee is interdisciplinary and includes, but not limited to the QI/Risk/IFC Manager, Facility Administrator, Medical Director and Clinical Managers. Other members such as supervising radiologist, pharmacy nurse etc will be added to the committee as indicated by the agenda. The committee is designed to provide upper management support and direction for improvement efforts.

The following staff members will be assuming the following roles for the year 2018, upon approval from the MEC and Governing Body:

Quality Improvement Committee Chair: [REDACTED]

Risk Manager: [REDACTED]

Infection Control Coordinator: [REDACTED]

Patient Safety Committee Chair: [REDACTED]

Radiation Safety Officer

Key activities:

- Establish and oversee ongoing measurement, periodic review, and improvement of key processes
- Assist in identifying opportunities for improvement and participate in QI studies. In addition conduct re-audits to assure the changes have remained effective
- Participate in Ambulatory Surgery Division quality, risk and patient safety initiatives including Best Practices
- Communicate relevant activities, as necessary, to the staff
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors
- Serve as a resource for patient safety/regulatory issues and for the regulatory component of accrediting agencies
- Provide periodic reports on quality improvement activities to Medical Executive Committee and Governing Board
- Educate staff on quality, risk and patient safety activities

Quality Studies: Quality studies will reflect the scope of services, priorities and findings from performance monitoring or other sources. Studies will address clinical, administrative, and/or cost of care issues and will be documented in the (10) step format which includes:

- State the purpose of the process improvement opportunity/purpose of the study
- Identify the goal of the study
- Description of data to be collected and established criteria
- Evidence of Data Collected
- Data analysis
- Comparison of actual data to goal
- Development of corrective action and execution timeline
- Re-measurement and monitoring to determine if actions have been achieved and improvements are sustained
- Development of additional corrective actions if needed
- Communication of results to appropriate personnel, MEC and Governing Board

Staff Education: The staff receives an orientation on quality improvement, risk management, infection control and patient/employee safety initiatives to be completed within 30 days of employment as part of new employee orientation. At least annually, a review of the process and accomplishments will be conducted through an appropriate mechanism. Clinical leaders will receive periodic training on any updates to initiatives, new statistical reporting or other information as indicated.

Ongoing Measurement: Ongoing measurement is overseen by the Quality/Risk Manager in collaboration with the Facility Administrator and Medical Director. These are outlined on the addendum to this plan.

Design of New Processes: When Las Vegas Surgery Center is considering a new process (for example, providing a new patient service, constructing a new facility, or redesigning an existing service), a multidisciplinary team will be convened to ensure that the process considers:

- The organization's mission, vision and strategic plans
- Patient and community needs
- Information about performance and outcomes of the process (including information from reference data bases)
- Current evidence based practice and research
- Current regulatory standards

Periodic Assessment and Improvement: Based on ongoing review of measurement data, this plan provides assessment of data against historical trends and available benchmarks whenever possible. All measures are reviewed quarterly by the Quality Committee, Medical Executive Committee and Governing Board.

Assessment is automatically triggered for any of the following:

- By any sentinel event
- By important undesirable single events, which include at a minimum:
 - Credentialing or bylaw violation
 - "Close call / Near miss" event
 - Significant injury or death
 - Any significant untoward event during moderate sedation or anesthesia
 - Any serious adverse drug or medication error event
 - Any significant hazardous condition
 - Any significant infection control breach or trend
- By important undesirable patterns or trends, which include at a minimum:
 - Staffing effectiveness or clinical issues
 - Any quality measure that varies substantially from an expected range
 - When the organization's performance significantly varies below that of other ambulatory surgery settings or recognized standards

Select quality data is submitted to corporate and trended with internal benchmarks across the company. This information is shared at the facility, division and corporate level. This information is used to develop corporate wide quality and risk initiatives and for external benchmarking in the ambulatory surgery arena.

In addition to ongoing measurement, the Center may at any time proactively assess its culture of patient safety as well as specific processes of care that have been within the healthcare industry as having the potential to harm patients. Also the Center may periodically assess processes using tools provided from a variety of outside sources to identify potential risks to patients and opportunities for improvement.

ONGOING QUALITY AND RISK MANAGEMENT - PERFORMANCE MEASUREMENTS

Customer Satisfaction Surveys

- Patient surveys done after discharge (written survey, call, email)
- Post op phone calls
- Employee Surveys as designated by corporate
- Physician surveys as designated by corporate
- Patient complaints (response and corrective action)
- Physician complaints (response and corrective action)

Patient Flow

- On time start of surgical cases
- Consistent delays in surgeries
- Turn around time
- Cases pulled correctly
- Equipment issues
- Cancelled cases (pre and intra-op)

Anesthesia Care

- Conscious sedation monitoring standards are standardized and consistent
- Anesthesia Care: complication rates for general/regional, assessment and plan of care developed prior to the start of anesthesia, physiological monitoring
- Annual malignant hyperthermia drill

Pre-op Care

- Completion of One Medical Passport prior to day of procedure
- Use of anesthesia alerts to evaluate patient medical history to determine if patient a candidate for the ambulatory surgery setting
- Appropriate follow through on obtaining pre-op diagnostic studies per anesthesia guidelines and follow up on abnormal reports
- Pre op instructions
- DVT assessment –including use of SCD when indicated
- Falls Assessment
- Sleep Apnea assessment and Incentive Spirometer started on designated patient population (if applicable)

Intra-op Care and Processes

- Time Out/correct site process
- Retained foreign bodies
- Wrong sites
- Near misses / close calls
- Blood usages
- Complications

Complications

- Unexpected complications
- Post op DVT/PE
- Transfers to acute care (Direct Hospital Admits/ ER Transfers)
- Hospitalization or ED visit within 72 hours of discharge (Indirect Hospital Admits / ER visits)
- Variances of expected performance through clinical record review
- Mortality within 7 days of procedure or related to procedure.
- Falls
- Burns
- Loss of Vision
- Unplanned vitrectomy following cataract surgery

Resuscitation / Emergency Response

- Code blue drill(s) - Adult and Pediatric if there is a pediatric population
- Malignant Hyperthermia drill
- Emergent Blood drill
- Crash carts, Malignant Hyperthermia carts checked according to policy
- Lipid rescue drill

Diagnostics Results

- Pre-op diagnostic studies clinically reviewed and documented.
- Pre- and post operative diagnosis agreement

Medication Usage

- Utilize "One Source" truth for allergy documentation
- Medication Reconciliation process
- Use of Medication Administration Record (MAR) for consistency in medication documentation
- Medication errors
- Adverse drug reactions
- Appropriate labeling of high alert and look alike/sound alike medications

- Independent double checks with administration of designated high risk medications
- Controlled substance audits
- External pharmacy audits
- Surveillance of security of medications and needles
- Verbal and telephone orders are read back and verified
- Appropriate medication ordering, preparation and administration of medications.
- Utilizing approved compounding pharmacies and continual monitoring for FDA alerts.

Infection Control

- Annual infection control risk assessment (ICRA)
- Proactive influenza vaccination program
- Compliance with hand washing standards- direct observation.
- Monitor compliance with cleaning protocols
- No use of razors except for urology cases
- Appropriate timing of pre-op prophylactic antibiotic administration
- Post-op infections (rate, type of organism, environmental causes) within 30 days of surgery
- Implant monitoring for 90 days
- OSHA training during orientation and annually
- Employee, physician, allied health and patient exposures
- Appropriate sterilization processes for instrumentation (quarterly audits – HCA BoosterPak)
- Appropriate endoscopy re-processing (quarterly audits – HCA BoosterPak)
- Monitoring IUSS rates monthly
- 24/7 Monitoring of temperature and humidity of designated rooms

Provision of Care/ Medical Record Review

- Appropriate credentialing of medical staff
- Physician H&P on chart prior to start of surgery
- H&P reviewed on day of surgery and updated if indicated to include patient acceptable candidate for ASC setting
- Required elements of assessment documented
- Pain assessment on admission, during Phase I and prior to discharge
- Fall assessment during admission process and discharge
- Operative reports: timeliness, content, intra-operative progress note completion
- Appropriate monitoring during IV conscious sedation by non-anesthesia personnel
- Timely medical record completion
- Medication Reconciliation completed

Equipment

- Routine preventive maintenance
- Compliance with process of notification and removal of malfunctioning equipment.
- Initial and annual competencies
- Utilize "One Source" to verify appropriate use of equipment

Safety

- Surveillance rounds and corrective follow up on deficiencies
- Process for notifying and following through on recalls
- Periodic checks for life safety and environmental equipment
- Fire drills
- Emergency preparedness drills
- Infant/child abduction drill

- Sharps prevention program
- Incapacitated healthcare provider drill
- Active Shooter drill

Emergency Preparedness

- Develop a Hazardous Vulnerability Analysis (HVAC) grid
- Written emergency preparedness plan that incorporates community resources
- Emergency preparedness drills and critiques
- Active Shooter Drill
- Incapacitated and/or Impaired healthcare provider

Radiation Safety

- Staff and physician training in radiation safety
- Physician and staff training in use of C-arms
- Compliance with radiation safety measures- direct observation
- Appropriate use of radiology equipment and shielding
- Dosimeter badge reports

Patient Safety

- Use of two patient identifiers- direct observation
- One source truth for allergies noted and communicated
- Time out verification for procedures
- Surgical Site marking
- Appropriate use of abbreviations
- Latex allergy precautions
- Falls prevention guidelines
- DVT assessment
- Close calls
- Hand off communication

EVALUATION OF THE 2017 QUALITY PROGRAM

1. Evaluation of 2017 Quality/Risk/Patient Safety Plan

- 100% Grievances entered into Risk Management workbook **and addressed** within time frame dictated by policy in 2017. (# grievances within time frame / #total grievances entered)
- 100% staff that received annual Risk Management In-service in 2017. (#33)
- 100% compliance with 2017 Clinical Safety Improvement Program - CSIP
- 100% of the HCA High Level Disinfection & Central Sterile Processing Boosterpak deliverables met
- 100% (3) Sentinel Events in 2017 and SEA completed for each adverse event.
- List Quality Studies completed in 2017:
 - Hypertension following a nasal procedure on a specific physician
 - IUSS rates
 - Patient falls
- Comments:

2. Evaluation of 2017 Goals – met / not met (if not met – Explain)

A. Division Goals

- To reduce the number of sharp occurrences - not met.

- All FWD centers reported a sharp occurrence in 2017 – 37 total occurrences. All but one occurred in the OR.
- To reduce the number of patient falls – not met.
 - Centers reporting patient falls in 2017 have deviated from the falls prevention practices as specified in the falls prevention toolkit.
- To increase the OMP usage - met
- 100% compliance in Prophylactic IV antibiotic administration - met.
- To complete the 2017 Risk Reduction Program Initiatives. – not met.
 - All but 1 FWD ASC reported a 100% compliance.
- To meet the 2017 ASD Clinical Objectives - met.

B. Center specific Goals

- List your 2017 center specific goals here – explain if not met
- To decrease the IUSS rate by 25%. – The center decreased IUSS by 19% from 12/16 – 12/17. The center continues to order additional instruments to further reduce the percentage.
- Continue using the Infection Control Rounding Tool monthly.
- To encourage the use of One Medical Passport to increase our percentage rate to 85%. The result was 67%. This was not met due to patient population and not having sufficient staff to create the passport over the telephone.
- The Passport and the Time Out process must be followed accurately and completely.
- The process of intraocular instrumentation must be evaluated monthly using the audit form and be completed by the OR Charge nurse and Sterile Supply Technician.

2018 QUALITY / RISK GOALS

2018 ASD Clinical Agenda

- Industry leading quality and service
 - Assessment and promotion of a patient safety culture through the Culture of Safety Survey (CSIP)
 - Continued verification of clinical standards through perpetual Survey Readiness
 - Prevention of serious events through ASD wide shared learning calls (CSIP)
- Profitable growth through distinctive MD and patient relationships and value
 - Support and develop physician leaders through the Medical Directors' engagement program (CSIP)
 - Provide specific clinical guidance to expand service lines through:
 - Total Joint Replacement Program Workbook
 - Partner with local GME programs
 - Initiate Professional Performance Evaluation Program for medical staff and advanced practice providers
- Efficiency levels that continue to lead the industry
 - Facilitate safe Medication Management strategies (CSIP)
 - Ensure accurate and timely Clinical Records
 - Analysis/transparency of data through:
 - Quarterly Clinical Operations calls (Division)
 - SQI enhancements (Division)
- A well-informed response to evolving market environment
 - Assessment and support of post-operative Normothermia to reduce untoward outcomes

- Evaluate ophthalmologic outcomes through reporting and assessment of unplanned vitrectomies
- Enhance Patient Experience by utilization of a standardized patient experience of care survey
- Unparalleled development of future leaders
 - Expedite the development of new leaders through:
 - CSP and Endoscopy Reprocessing ongoing certification
 - CSG ASD Orientation (3 times: February, May, August)
 - Quality and Risk Management Manual

2018 Division Goals

- To continue to reduce the number of sharp occurrences by implementing & sustaining the practices in the sharps safety toolkit.
- To implement the Burn Prevention Toolkit division - wide.
- To complete the 2018 Clinical Safety Improvement (CSIP) Program.
- To meet the 2018 ASD Clinical Objectives

2018 Center Goals

- To continue to identify areas of opportunity to reduce the IUSS rate, and to sustain the IUSS rate \leq 10% (as per HCA recommendation).
- To complete the 2018 Clinical Safety Improvement (CSIP) Program.
- To meet the 2018 ASD Clinical Objectives
- To decrease the amount of in-direct hospital admits by 25%

PRESENT TO QI/MEC/GB - FIRST MEETING OF 2018

REFERENCED ORGANIZATIONS

AAAHHC- Accreditation Association for Ambulatory Health Care, Inc., <http://www.aaahc.org/>

CDC- Centers for Disease Control and Prevention, <https://www.cdc.gov/>

CMS-Centers for Medicare and Medicaid Services, <https://www.cms.gov/>

FDA- Food & Drug Administration, <https://www.fda.gov/>

NQF- National Quality Forum, <http://www.qualityforum.org/Home.aspx>

NPSF-National Patient Safety Foundation, <http://www.npsf.org/>

SMDA-Safe Medical Device Act, <https://www.fda.gov/MedicalDevices/Safety/ReportaProblem/default.htm>

VA Patient Safety PROGRAM, VA National Center for Patient Safety, <https://www.patientsafety.va.gov/>

WHO- World Health Organization, WHO.Int

QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN

FLAMINGO SURGERY CENTER 2019

Revised 01/16/2019

The mission of Flamingo Surgery Center is focused on delivering the highest quality, cost effective healthcare that effectively responds to the needs and safety of our patients by minimizing the possibility for injury or harm to our patients. We are committed to the care, dignity and improvement of human life to the patient populations we serve.

In keeping with the mission of the Flamingo Surgery Center, the community, HCA initiatives, and regulatory standards for ambulatory surgical care, this plan allows for a planned, systematic, organization-wide approach to the quality improvement process, and assessing opportunities to reduce risk. This is accomplished through an effective risk and quality program, as well as, a medication and radiation safety plan that are all targeted toward improving patient safety. The activities will be carried out in a collaborative and interdisciplinary manner. When identified, individual competency issues and process changes will be coordinated with the management team and human resources. The overall strategies of the program include

- Improving patient safety and reducing risk to patients which includes, but not limited to medication and radiation safety, safe quality care and reducing risk of injury to patients and staff;
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety;
- Assuring that quality improvement initiatives continue to focus on high priority areas of clinical care, monitoring of process and outcome indicators; redesigning processes and systems and providing education to foster improvement;
- Positioning Flamingo Surgery Center to achieve earning expectations and maintain effective cost-containment strategies while providing high quality of patient care, and
- Meeting the expectations of the HCA internal initiatives, as well as, the external regulatory agencies and accrediting bodies through the identification of opportunities to improve patient care, demonstration of appropriate action taken, and follow up on the effectiveness of action taken.

Strategies will be incorporated in each of the following areas to identify opportunities and set goals to achieve and sustain the desired results in striving to become a high reliability organization (HR):

- Performance Improvement Processes
- Quality studies
- Risk Management Strategies
- Patient Safety Initiatives
- Infection Control Strategies
- Medication Safety Strategies
- Radiation Safety Initiatives

HCA Patient Safety Organization (PSO), LLC

HCA established a Patient Safety Organization, LLC in spring of 2014 in accordance with provisions of the Patient Safety and Quality Improvement Act (Public Law 109-41). The PSO is a component of its parent entity, HCA. The mission of the PSO is to conduct activities to improve patient safety and the quality of healthcare delivery. The vision is to assist participating providers in the elimination of preventable patient harm. The activities of the organization include:

- Improve patient safety and the quality of health care delivery
- Collect and analyze Patient Safety Work Product (PSWP)
- Develop and disseminate information regarding patient safety
- Utilize PSWP to encourage a culture of safety and provide assistance to effectively minimize patient risk.
- Maintain procedures to preserve confidentiality and provide appropriate security of PSWP
- Utilize qualified medical personnel
- Operate a patient safety evaluation system (PSES) and provide feedback to participants of the PSO
- Utilize the Serious Event Analysis (SEA) process to identify the root causes of serious patient adverse events, per policy.

Flamingo Surgery Center is a member of the HCA Patient Safety Organization (PSO), LLC. The Administrator serves as the designated PSO Contact and oversees all activities of the PSO for the center, while the Risk/Quality Manager shall serve as the Contact Designee. The Center will provide patient safety work product (PSWP) documents as requested by the PSO. The center will receive information from the PSES to evaluate opportunities for improving patient safety and quality care. All information submitted will remain confidential within the PSO.

Quality Improvement Plan

The Center maintains an ongoing quality improvement program that has a broad scope to address administrative, clinical, and cost effective performance. The program also addresses patient outcomes, patient care processes, as well as, medication, radiation and patient safety. Elements of the program include, but are not limited to a

- Written plan that addresses the scope of health care services provided by the Center and how the quality improvement plan for these services are assessed.
- Interdisciplinary QI committee for the development, implementation, review and oversight of the program. The committee has administrative, clinical and physician participation.
- Set goals and objectives that are reviewed and updated at least annually.
- Quality improvement activities such as audits and studies to identify problems with processes or patient care. The studies will be done utilizing the ten (10)-step process that is encouraged by the Accreditation Association for Ambulatory Healthcare (AAAHHC).
- Measurement of data against internal and external benchmarking sources.
- Annual reviews of the effectiveness of the program.
- Periodic reports to Governing Body that encompass a summary of the quality improvement activities, findings and process changes if indicated.

Risk Management and Patient Safety

Definitions of Potential Risk Issues

Event: A discrete, auditable and clearly defined occurrence (National Quality Forum).

Occurrence: The action, fact, or instance of something that happens synonymous with an event;

An event, situation, or process that contributes to, or has the potential to contribute to, a patient or visitor injury, or degrade our ability to provide optimal patient care. Reportable occurrences can generally be divided into the following types based on severity: Sentinel events, patient and visitor injuries, [adverse events], near misses (close calls, good catches etc.), and safety concerns. (National Patient Safety Foundation,)

Incident: Synonymous with occurrence or event. An occurrence or event that interrupts normal procedure and can precipitate an untoward or unplanned outcome an unusual event that occurs at the facility, such as an injury to a patient. Involved damage that is limited to parts of a unit, whether the failure disrupts the system or not. (NPSF). A patient safety event that reached the patient, whether or not the patient was harmed (NQF).

Adverse Event:

A patient safety event that resulted in harm to a patient. (The Joint Commission, 2018).

Any injury caused by medical care. Examples:

- o pneumothorax from central venous catheter placement;
- o anaphylaxis to penicillin;
- o postoperative wound infection;
- o hospital-acquired delirium (or "sun downing") in elderly patients.

Identifying an event as adverse does not imply "error," "negligence," or poor quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis, treatment or therapy, as opposed to an underlying disease process. Thus, pneumothorax from central venous catheter placement counts as an Adverse Event regardless of insertion technique. Similarly, postoperative wound infections count as adverse events even if the operation proceeded with optimal adherence to sterile procedures and the patient received appropriate antibiotic prophylaxis in the perioperative setting. (Agency for Healthcare Research and Quality, Patient Safety Network- AHRQ, PSNet)

Sentinel Event: A Patient Safety Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel Events are a subcategory of Adverse Events. (The Joint Commission, 2018).

n adverse event in which death or serious harm to a patient has occurred, usually used to refer to events that are not at all expected or acceptable—e.g., an operation on the wrong patient or body part. The choice of the word sentinel reflects the egregiousness of the injury (e.g., amputation of the wrong leg) and the likelihood that investigation of such events will reveal serious problems in current policies or procedures. (Agency for Healthcare Research and Quality PSNet)

Serious Patient Adverse Event or SPAE: A Patient Safety Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and may result in any of the following:

- Death
- Permanent harm
- Severe temporary harm, or risk thereof

Such an event may result in patient injury as well as cause damage to the Facility and/or HCA's reputation as well as the Facility's accreditation, certification or licensure.

Close Call (Near Misses/Good Catches): Events or situations that could have resulted in an adverse event (accident, injury, or illness), but did not, whether by chance or through timely intervention. Such events have also been referred to as "near miss" incidents. An example of a close call would be a surgery or other procedure almost performed on the wrong patient due to lapses in verification of patient identification, but caught prior to the procedure (Source: VA Patient Safety Program).

Serious Event Analysis (SEA): A method of problem solving that attempts to identify the root causes of a process or processes. The SEA process tries to evaluate the underlying "whys" for the variances and solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing on the correction of root causes, problem recurrence can be prevented. An analysis is done *after* an event has occurred. All staff members involved, as well as, the Risk Manager and physicians involved shall participate in the SEA analysis The SEA process is typically used as a reactive method of identifying event(s) causes, revealing problems and identifying opportunities to reduce the risk of future occurrences. The SEA action plan is reported at the quality meetings, MEC and GB meetings.

Risk Management

The Center maintains an ongoing risk management program designed to protect the life, safety and welfare of the patients and employees. Risk management addresses strategies from the organizational, operational, human resource and liability areas of the organization. Goals of the program may include, but are not limited to:

- Improving patient safety and reducing risk to patients;
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety
- Reviewing and tracking of variance reports and litigations for trends.
- Reviewing and tracking of adverse outcomes, near misses (close calls) or sentinel events to identify gaps or opportunities for improvement.
- Maintaining a strong credentialing and privileging process and current bylaws that meet community standards
- Keeping abreast of current standards for risk management and adapting practice and policies that are compliant with standards.

It is evident through the goals, activities and processes that the quality improvement and risk management programs intertwine and cross all spectrums of the organization. Quality care, as well as patient and employee safety is at the center focus of both programs. The operational linkage between Risk management, Safety, Quality and Infection Control is accomplished through the following mechanisms:

- Issues or trends identified through chart reviews, peer reviews, safety, radiation and infection control rounds are discussed and referred to the appropriate department for evaluation and/or corrective action
- Data from variances that identified trends, adverse events or any events that impact the quality or safety of patient care will be reviewed and referred to appropriate risk and leadership personnel for investigation, analysis and corrective action
- The Risk manager will review current issues and risk reduction strategies with appropriate personnel and develop a plan of action. This will be reported to MEC/GB.
- The Quality Committee will serve as the oversight committee for Patient Safety, Risk Management, Infection Control. Medication Safety and Radiation Safety fall within a subsection of the Quality Committee and will be addressed as indicated.

These plans engage active involvement of all members of the healthcare team, as well as patients, families and physicians, addressing an environment which:

- Encourages recognition and acknowledgment of opportunities to improve quality performance and to reduce risks to patient safety,
- Initiates actions to improve processes or reduce these risks,
- Encourages internal reporting of what has been found and the actions taken;
- Focuses on processes and system,
- Minimizes individual blame or retribution for involvement in a medical/health care error; and
- Challenges leaders of the organization to be responsible for fostering a “non punitive” culture of continuous improvement, reducing risk and creating a safe environment for patients, employees and physicians.

Medication Safety

A designated pharmacist (consultant or regional HCA) oversees the medication practices and processes at the Center. Their duties include, but are not limited to

- Conducting medication rounds and audits providing feedback on areas of opportunities. This includes validation of medication safety practices.
- Adhering to strict processes for ordering, administration and tracking of controlled substances.
- Collaborating with the Center on choice of pharmaceutical vendors and formularies
- Collaborating with the Center on policy review and development

- Participating in review of any medication error or diversion
- Assuring controlled substance ordering and monitoring is in accordance with state and federal regulations

All relevant activities are reported through QI/MEC/GB.

Radiation Safety

This facility utilizes radiation emitting equipment and therefore, by direction of the Governing Body/Board. Radiation Safety will be a subgroup of representatives to be included under the QI/Safety/Risk committee to report radiation safety activities. Key activities are established by the Radiation Right policies identified as CSG.MI.001 Governance and CSG.MI.003 Fluoroscopy:

- Designate an individual that is approved by MEC/GB to oversee the program
- Oversee ongoing measurement, periodic review, and improvement of key radiation safety practices and provide a quarterly report to the QI/Risk/Safety committee (Quarterly rounds)
- Periodic maintenance of equipment
- Maintaining and reviewing exposure time logs
- Communicate relevant radiation safety activities, as necessary, to the staff.
- Serve as a resource for radiation safety as it relates to staff and patient safety/regulatory issues and for the regulatory component of accrediting agencies.
- Educate staff on radiation safety practices

Infection Control

The Center conducts an annual infection control risk assessment in order to identify areas of opportunities to reduce the risk of infections (Refer to Infection Control Plan, IFC). All activities are reported through QI/MEC/GB.

Peer Review Ambulatory Surgery Centers are required by AAAHC, CMS, and other regulatory agencies to conduct quality improvement and peer review on medical staff members and allied health professionals. Peer review activities include ongoing, specialty specific review and review of variances. Peer Review will be conducted in accordance with the peer review policy and medical staff bylaws.

Confidentiality

All quality improvement and peer review activities and data are considered confidential. Any requests by outside sources for any QI, Risk management, Peer Review or credentialing information or reports will be forwarded to the appropriate HCA administrative/corporate staff when indicated.

ORGANIZATION STRUCTURE AND PROCEDURE

Role of Leadership

Leaders play a key role in facilitating improvement and ensuring a safe environment. The Flamingo Surgery Center leadership includes the Governing Body, Medical Executive Committee; the facility based Medical Directors, Administrators, Risk/Quality/Safety/Radiation Safety/Infection Control designees and Clinical Managers. Leaders foster quality improvement through planning, educating, setting priorities, providing support such as time and resources, and empowering staff as appropriate.

Governing Board/Medical Executive Committee

The Board has the ultimate authority and accountability for the quality and risk programs to ensure that the quality of patient care is provided in an efficient, safe, timely and cost-effective manner. The Governing Body provides support for the improvement strategies and delegates to the Medical Executive Committee and leaderships at each facility, the authority to perform assessment and improvement activities through committees and teams. Quarterly, the Governing Body shall receive a report on the activities of the quality and risk management programs. These functions include, but not limited to:

- Assure QI/Risk/Radiation/Medication/Patient Safety is an integral part of the Center's objectives, plans and management structure
- Provide resources to support the QI/Risk/Patient Safety programs.
- Assure that improvements are sustained and evaluated for effectiveness
- Review and approve policies, reports, QI/Risk/Safety/IFC data collection and analysis, the QI/Risk/Patient Safety plans and annual evaluation.

Administration

The Center Administrator is responsible for providing qualified personnel to support the proper functioning of quality improvement and risk management activities. Administration will participate in performance improvement activities and in the assignment of priorities to the functions identified by performance improvement activities.

Key Goals:

- Assure patient care is delivered safely
- Ensure the ongoing competencies of the staff
- Support an environment that promotes process improvement, quality outcomes, reduction in risk, patient and employee safety and customer satisfaction
- Oversee reviewing and keeping current with regulatory standards (CMS,CDC, state and AAAHC)

Key Activities:

- Develop specific goals, objectives, and targets for quality improvement, risk management, infection control, as well as, radiation/medication/ patient safety.
- Designate responsibility to qualified individuals or an interdisciplinary committee for ensuring that quality and risk goals/objectives, as well as patient safety are achieved.
- Provide adequate time and training, as well as resources, for personnel to participate in quality improvement activities and to improve patient safety.
- Assure clear systems and policies/procedures for internal and external reporting of information relating to performance indicators/measures and medical/health care errors.
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors. Actively encouraging all staff to identify and report hazardous conditions and errors in a blame-free environment.
- Establish or supporting changes in processes, functions and services to sustain improved performance and to prevent recurrence and reduce risk to patients.
- Assure the effectiveness of the quality and risk management goals/objectives and contributions to improving patient safety are measured and assessed annually.

Quality Improvement/ Risk/Infection Control/Radiation Safety/Medication Safety/Patient Safety Committee

Each facility has a quality improvement committee, which derives goals from the Governing Body, Medical Executive Committee, Administration, staff and other sources. Primary responsibility of this committee is to maintain a culture of patient safety throughout all patient care processes and organizational functions. This committee is interdisciplinary and includes, but not limited to the QI/Risk/IFC Manager, Facility Administrator, Medical Director and Clinical Managers. Other members such as supervising radiologist, pharmacy nurse etc will be added to the committee as indicated by the agenda. The committee is designed to provide upper management support and direction for improvement efforts.

Key activities:

- Establish and oversee ongoing measurement, periodic review, and improvement of key processes
- Assist in identifying opportunities for improvement and participate in QI studies.
- Participate in Ambulatory Surgery Division quality, risk and patient safety initiatives including Best Practices
- Communicate relevant activities, as necessary, to the staff.
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors

- Serve as a resource for patient safety/regulatory issues and for the regulatory component of accrediting agencies.
- Provide periodic reports on quality improvement activities to Medical Executive Committee and Governing Board.
- Educate staff on quality, risk and patient safety activities

Quality Studies

Quality studies will reflect the scope of services, priorities and findings from performance monitoring or other sources. Studies will address clinical, administrative, and/or cost of care issues and will be documented in the (10) step format, which includes:

- State the purpose of the process improvement opportunity/purpose of the study
- Identify the goal of the study
- Description of data to be collected and established criteria
- Evidence of Data Collected
- Data analysis
- Comparison of actual data to goal
- Development of corrective action and execution timeline
- Re-measurement and monitoring to determine if actions have been achieved and improvements are sustained
- Development of additional corrective actions if needed
- Communication of results to appropriate personnel, MEC and Governing Board

Staff Education

The staff receives an orientation on quality improvement, risk management, infection control and patient/employee safety initiatives within 30 days of employment as part of new employee orientation. At least annually, a review of the process and accomplishments will be conducted through an appropriate mechanism. Clinical leaders will receive periodic training on any updates to initiatives, new statistical reporting or other information as indicated.

Ongoing Measurement

The Quality/Risk Manager in collaboration with the Facility Administrator and Medical Director oversees ongoing measurement. These are outlined on the addendum to this plan.

Design of New Processes

When the Center is considering a new process (for example, providing a new patient service, constructing a new facility, or redesigning an existing service), a multidisciplinary team will be convened to ensure that the process considers:

- The organization's mission, vision and strategic plans;
- Patient and community needs;
- Information about performance and outcomes of the process (including information from reference data bases).
- Current evidence based practice and research
- Current regulatory standards

Periodic Assessment and Improvement

Based on ongoing review of measurement data, this plan provides for assessment of data against historical trends and available benchmarks whenever possible. The Quality Committee, Medical Executive Committee and Governing Board review all measures quarterly.

Assessment may be triggered for any of the following:

- By any sentinel event;
- By important undesirable single events, which may include:

- “Near miss” events
 - Significant injury or death
 - Any significant untoward event during moderate sedation or anesthesia;
 - Any serious adverse drug or medication error event; and
 - Any significant hazardous condition.
 - Any significant infection control breach or trend
- By important undesirable patterns or trends, which may include:
 - Staffing effectiveness or clinical issues;
 - Any quality measure that varies substantially from an expected range; and
 - When the organization’s performance significantly varies below that of other ambulatory surgery settings or recognized standards.

Select quality data is submitted to HCA and trended with internal benchmarks across the company. This information is shared at the facility, division and enterprise level. This information is used to develop division and enterprise wide quality and risk initiatives and for external benchmarking in the ambulatory surgery arena.

In addition to ongoing measurement, the Center may at any time proactively assess its culture of patient safety as well as specific processes of care that have been identified within the healthcare industry as having the potential to harm patients. The Center may periodically assess processes using tools provided from a variety of outside sources to identify potential risks to patients and opportunities for improvement.

REFERENCED ORGANIZATIONS

AAAHc- Accreditation Association for Ambulatory Health Care, Inc., <http://www.aaahc.org/>
AHRQ – Agency for Healthcare Research and Quality, <https://www.ahrq.gov/>
CDC- Centers for Disease Control and Prevention, <https://www.cdc.gov/>
CMS-Centers for Medicare and Medicaid Services, <https://www.cms.gov/>
FDA- Food & Drug Administration, <https://www.fda.gov/>
NQF- National Quality Forum, <http://www.qualityforum.org/Home.aspx>
NPSF-National Patient Safety Foundation, <http://www.npsf.org/>
SMDA-Safe Medical Device Act, <https://www.fda.gov/MedicalDevices/Safety/ReportaProblem/default.htm>
VA Patient Safety PROGRAM, VA National Center for Patient Safety, <https://www.patientsafety.va.gov/>
WHO- World Health Organization, WHO.Int

ONGOING QUALITY AND RISK MANAGEMENT PERFORMANCE MEASUREMENTS (as applicable)

Customer Satisfaction Surveys

- Patient surveys done after discharge (Press Ganey)
- Post op phone calls
- Employee Surveys as designated by HCA
- Physician surveys as designated by HCA
- Patient grievances (response and corrective action)
- Physician complaints (response and corrective action)

Patient Flow

- On time start and flow of surgical cases
- Consistent delays in surgeries
- Turn around time
- Equipment issues
- Cancelled cases (pre and intra-op)

Anesthesia Care

- Conscious sedation monitoring standards are standardized and consistent
- Anesthesia Care: complications for general/regional, assessment and plan of care developed prior to the start of anesthesia, physiological monitoring

Pre-op Care

- Completion of One Medical Passport prior to day of procedure
- Use of anesthesia alerts to evaluate patient medical history to determine if patient a candidate for ambulatory surgery setting.
- Appropriate follow through on obtaining pre-op diagnostic studies per anesthesia guidelines and follow up on abnormal reports
- Pre op instructions
- DVT assessment –including use of SCD when indicated
- Falls Assessment
- Sleep Apnea assessment and Incentive Spirometer started on designated patient population (if applicable)

Intra-op Care and Processes

- Time Out/correct site process
- Retained foreign bodies
- Wrong sites
- Near misses
- Blood utilization

Complications

- Unexpected complications (during any phase of care)
- Post op DVT/PE
- Transfers to acute care (Direct Admits)
- Hospitalization or ED visit within 72 hours of discharge (Indirect Admits)
- Variances of expected performance through clinical record review
- Mortality within 7 days of procedure or related to procedure.
- Falls
- Burns
- Loss of Vision
- Unplanned vitrectomy following cataract surgery.(if applicable)
- TASS (if applicable)
- Monitor post op progress of total joints weekly until discharged by surgeon

Resuscitation

- Code blue drill(s)- Adult and Pediatric (if there is a pediatric population)
- Crash carts, Malignant Hyperthermia carts maintained according to policy
- Annual malignant hyperthermia drill
- Periodic lipid rescue drills (If applicable).

Diagnostics Results

- Pre-op diagnostic studies clinically reviewed and documented.
- Pre- and post operative diagnosis agreement

Medication Usage

- Utilize “One Source” truth for allergy documentation
- Medication Reconciliation process
- Medication errors

- Adverse drug reactions
- Appropriate labeling of high alert and look alike/sound alike medications
- Independent double checks of designated high risk medications
- Controlled substance audits with follow up on deficiencies noted
- Surveillance of security of medications and needles

Infection Control

- Annual infection control risk assessment
- Proactive influenza vaccination program
- Compliance with hand washing standards- direct observation.
- Compliance with cleaning protocols
- Compliance with appropriate pre-op hair removal
- Appropriate timing of pre-op prophylactic antibiotic administration
- Monitoring Normothermia for patients undergoing surgery > one hour
- Post-op infections (rate, type of organism, environmental causes) within 30 days of surgery
- Implant monitoring for 90 days
- OSHA training during orientation and annually
- Employee, physician, allied health and patient exposures
- Appropriate sterilization processes for instrumentation
- Appropriate endoscopy re-processing if applicable
- Monitoring of temperature and humidity of designated rooms
- Monitoring IUSS rates

Provision of Care/ Medical Record Review

- Appropriate credentialing and privileging of medical staff
- Physician H&P on chart prior to start of surgery
- H/P reviewed on day of surgery and updated if indicated
- Required elements of assessment documented
- Pain assessment on admission, during Phase I and prior to discharge
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- Operative reports: timeliness, content, intra-operative progress note completion
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- Medication Reconciliation completed

Equipment

- Routine preventive maintenance
- Compliance with process of notification and removal of malfunctioning equipment.
- Initial and annual competencies
- Utilize “One Source” to verify appropriate use of equipment.

Safety

- Surveillance rounds and corrective follow up on deficiencies
- Process for notifying and following through on recalls
- Periodic checks for life safety and environmental equipment
- Fire drills
- Infant/child abduction drill
- Incapacitated/impaired healthcare provider drills
- Sharps prevention program

Emergency Preparedness

- Develop a Hazardous Vulnerability Analysis(HVAC) grid

- Written emergency preparedness plan that incorporates community resources
- Emergency preparedness drills and critique
- Active Shooter drill

Radiation Safety

- Initial physician delineation of privilege, proof of training on equipment and safety training. Staff education on equipment training and safety during orientation and annually.
- Compliance with radiation safety measures
- Appropriate use of radiology equipment and shielding
- Dosimeter badge reports

Patient Safety

- Use of two patient identifiers- direct observation
- One source truth for allergies noted and communicated
- Time out verification for procedures
- Surgical Site marking
- Appropriate use of abbreviations
- Latex allergy precautions
- Falls prevention guidelines
- DVT assessment
- Close calls (good catches)
- Hand off communication

Revised 01/16/2019

QI/RISK GOALS for 2019

CSG/HCA Initiatives

Compliance with CSG initiatives

- Endoscopy Toolkit
- Conscious Sedation Guidance
- Medication Safety-Diversion Guidebook

Clinical Safety Improvement Program 2019 Goals

1. AHRQ Culture of Patient Safety Survey results- Action Items and Implementation
2. Medical Director Engagement
3. Medication Safety-Guidebook Adoption, MDT meetings
4. SEA & Safe Table call participation

2019 Center Goals

- **To continue to identify areas of opportunity to reduce the IUSS rate, and to sustain the IUSS rate <10% (as per HCA recommendation).**
- **To complete the 2019 Clinical Safety Improvement (CSIP) Program**
- **To reduce the number of sharps occurrences by 25%**
- **To reduce the number of direct transfers by 25%**
- **To reduce the number of burns by 100%**

QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN

SAHARA SURGERY CENTER 2019

Revised 12/26/2018

The mission of Sahara Surgery Center is focused on delivering the highest quality, cost effective healthcare that effectively responds to the needs and safety of our patients by minimizing the possibility for injury or harm to our patients. We are committed to the care, dignity and improvement of human life to the patient populations we serve.

In keeping with the mission of the Sahara Surgery Center, the community, HCA initiatives, and regulatory standards for ambulatory surgical care, this plan allows for a planned, systematic, organization-wide approach to the quality improvement process, and assessing opportunities to reduce risk. This is accomplished through an effective risk and quality program, as well as, a medication and radiation safety plan that are all targeted toward improving patient safety. The activities will be carried out in a collaborative and interdisciplinary manner. When identified, individual competency issues and process changes will be coordinated with the management team and human resources. The overall strategies of the program include

- Improving patient safety and reducing risk to patients which includes, but not limited to medication and radiation safety, safe quality care and reducing risk of injury to patients and staff;
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety;
- Assuring that quality improvement initiatives continue to focus on high priority areas of clinical care, monitoring of process and outcome indicators; redesigning processes and systems and providing education to foster improvement;
- Positioning Sahara Surgery Center to achieve earning expectations and maintain effective cost-containment strategies while providing high quality of patient care, and
- Meeting the expectations of the HCA internal initiatives, as well as, the external regulatory agencies and accrediting bodies through the identification of opportunities to improve patient care, demonstration of appropriate action taken, and follow up on the effectiveness of action taken.

Strategies will be incorporated in each of the following areas to identify opportunities and set goals to achieve and sustain the desired results in striving to become a high reliability organization (HR):

- Performance Improvement Processes
- Quality studies
- Risk Management Strategies
- Patient Safety Initiatives
- Infection Control Strategies
- Medication Safety Strategies
- Radiation Safety Initiatives

HCA Patient Safety Organization (PSO), LLC

HCA established a Patient Safety Organization, LLC in spring of 2014 in accordance with provisions of the Patient Safety and Quality Improvement Act (Public Law 109-41). The PSO is a component of its parent entity, HCA. The mission of the PSO is to conduct activities to improve patient safety and the quality of healthcare delivery. The vision is to assist participating providers in the elimination of preventable patient harm. The activities of the organization include:

- Improve patient safety and the quality of health care delivery
- Collect and analyze Patient Safety Work Product (PSWP)
- Develop and disseminate information regarding patient safety
- Utilize PSWP to encourage a culture of safety and provide assistance to effectively minimize patient risk.
- Maintain procedures to preserve confidentiality and provide appropriate security of PSWP
- Utilize qualified medical personnel
- Operate a patient safety evaluation system (PSES) and provide feedback to participants of the PSO
- Utilize the Serious Event Analysis (SEA) process to identify the root causes of serious patient adverse events, per policy.

Sahara Surgery Center is a member of the HCA Patient Safety Organization (PSO), LLC. The Administrator - serves as the designated PSO Contact and oversees all activities of the PSO for the center, while the Risk/Quality Manager shall serve as the Contact Designee. The Center will provide patient safety work product (PSWP) documents as requested by the PSO. The center will receive information from the PSES to evaluate opportunities for improving patient safety and quality care. All information submitted will remain confidential within the PSO.

Quality Improvement Plan

The Center maintains an ongoing quality improvement program that has a broad scope to address administrative, clinical, and cost effective performance. The program also addresses patient outcomes, patient care processes, as well as, medication, radiation and patient safety. Elements of the program include, but are not limited to a

- Written plan that addresses the scope of health care services provided by the Center and how the quality improvement plan for these services are assessed.
- Interdisciplinary QI committee for the development, implementation, review and oversight of the program. The committee has administrative, clinical and physician participation.
- Set goals and objectives that are reviewed and updated at least annually.
- Quality improvement activities such as audits and studies to identify problems with processes or patient care. The studies will be done utilizing the ten (10)-step process that is encouraged by the Accreditation Association for Ambulatory Healthcare (AAAH). .
- Measurement of data against internal and external benchmarking sources.
- Annual reviews of the effectiveness of the program.
- Periodic reports to Governing Body that encompass a summary of the quality improvement activities, findings and process changes if indicated.

Risk Management and Patient Safety

Definitions of Potential Risk Issues

Event: A discrete, auditable and clearly defined occurrence (**National Quality Forum**).

Occurrence: The action, fact, or instance of something that happens synonymous with an event;

An event, situation, or process that contributes to, or has the potential to contribute to, a patient or visitor injury, or degrade our ability to provide optimal patient care. Reportable occurrences can generally be divided into the following types based on severity: Sentinel events, patient and visitor injuries, [adverse events], near misses (close calls, good catches etc.), and safety concerns. (**National Patient Safety Foundation**.)

Incident: Synonymous with occurrence or event. An occurrence or event that interrupts normal procedure and can precipitate an untoward or unplanned outcome an unusual event that occurs at the facility, such as an injury to a patient. Involved damage that is limited to parts of a unit, whether the failure disrupts the system or not. (NPSF). A patient safety event that reached the patient, whether or not the patient was harmed (NQF).

Adverse Event:

A patient safety event that resulted in harm to a patient. (The Joint Commission, 2018).

Any injury caused by medical care. Examples:

- o pneumothorax from central venous catheter placement;
- o anaphylaxis to penicillin;
- o postoperative wound infection;
- o hospital-acquired delirium (or "sun downing") in elderly patients.

Identifying an event as adverse does not imply "error," "negligence," or poor quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis, treatment or therapy, as opposed to an underlying disease process. Thus, pneumothorax from central venous catheter placement counts as an Adverse Event regardless of insertion technique. Similarly, postoperative wound infections count as adverse events even if the operation proceeded with optimal adherence to sterile procedures and the patient received appropriate antibiotic prophylaxis in the perioperative setting. (Agency for Healthcare Research and Quality, Patient Safety Network- AHRQ, PSNet)

Sentinel Event: A Patient Safety Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel Events are a subcategory of Adverse Events. (The Joint Commission, 2018).

n adverse event in which death or serious harm to a patient has occurred, usually used to refer to events that are not at all expected or acceptable—e.g., an operation on the wrong patient or body part. The choice of the word sentinel reflects the egregiousness of the injury (e.g., amputation of the wrong leg) and the likelihood that investigation of such events will reveal serious problems in current policies or procedures. (Agency for Healthcare Research and Quality PSNet)

Serious Patient Adverse Event or SPAE: A Patient Safety Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and may result in any of the following:

- Death
- Permanent harm
- Severe temporary harm, or risk thereof

Such an event may result in patient injury as well as cause damage to the Facility and/or HCA's reputation as well as the Facility's accreditation, certification or licensure.

Close Call (Near Misses/Good Catches): Events or situations that could have resulted in an adverse event (accident, injury, or illness), but did not, whether by chance or through timely intervention. Such events have also been referred to as "near miss" incidents. An example of a close call would be a surgery or other procedure almost performed on the wrong patient due to lapses in verification of patient identification, but caught prior to the procedure (Source: VA Patient Safety Program).

Serious Event Analysis (SEA): A method of problem solving that attempts to identify the root causes of a process or processes. The SEA process tries to evaluate the underlying "whys" for the variances and solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing on the correction of root causes, problem recurrence can be prevented. An analysis is done *after* an event has occurred. All staff members involved, as well as, the Risk Manager and physicians involved shall participate in the SEA analysis The SEA process is typically used as a reactive method of identifying event(s) causes, revealing problems and identifying opportunities to reduce the risk of future occurrences. The SEA action plan is reported at the quality meetings, MEC and GB meetings.

Risk Management

The Center maintains an ongoing risk management program designed to protect the life, safety and welfare of the patients and employees. Risk management addresses strategies from the organizational, operational, human resource and liability areas of the organization. Goals of the program may include, but are not limited to:

- Improving patient safety and reducing risk to patients;
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety
- Reviewing and tracking of variance reports and litigations for trends.
- Reviewing and tracking of adverse outcomes, near misses (close calls) or sentinel events to identify gaps or opportunities for improvement.
- Maintaining a strong credentialing and privileging process and current bylaws that meet community standards
- Keeping abreast of current standards for risk management and adapting practice and policies that are compliant with standards.

It is evident through the goals, activities and processes that the quality improvement and risk management programs intertwine and cross all spectrums of the organization. Quality care, as well as patient and employee safety is at the center focus of both programs. The operational linkage between Risk management, Safety, Quality and Infection Control is accomplished through the following mechanisms:

- Issues or trends identified through chart reviews, peer reviews, safety, radiation and infection control rounds are discussed and referred to the appropriate department for evaluation and/or corrective action
- Data from variances that identified trends, adverse events or any events that impact the quality or safety of patient care will be reviewed and referred to appropriate risk and leadership personnel for investigation, analysis and corrective action
- The Risk manager will review current issues and risk reduction strategies with appropriate personnel and develop a plan of action. This will be reported to MEC/GB.
- The Quality Committee will serve as the oversight committee for Patient Safety, Risk Management, and Infection Control. Medication Safety and Radiation Safety fall within a subsection of the Quality Committee and will be addressed as indicated.

These plans engage active involvement of all members of the healthcare team, as well as patients, families and physicians, addressing an environment which:

- Encourages recognition and acknowledgment of opportunities to improve quality performance and to reduce risks to patient safety,
- Initiates actions to improve processes or reduce these risks,
- Encourages internal reporting of what has been found and the actions taken;
- Focuses on processes and system,
- Minimizes individual blame or retribution for involvement in a medical/health care error; and
- Challenges leaders of the organization to be responsible for fostering a “non punitive” culture of continuous improvement, reducing risk and creating a safe environment for patients, employees and physicians.

Medication Safety

A designated pharmacist (consultant or regional HCA) oversees the medication practices and processes at the Center. Their duties include, but are not limited to

- Conducting medication rounds and audits providing feedback on areas of opportunities. This includes validation of medication safety practices.
- Adhering to strict processes for ordering, administration and tracking of controlled substances.
- Collaborating with the Center on choice of pharmaceutical vendors and formularies
- Collaborating with the Center on policy review and development

- Participating in review of any medication error or diversion
- Assuring controlled substance ordering and monitoring is in accordance with state and federal regulations

All relevant activities are reported through QI/MEC/GB.

Radiation Safety

This facility utilizes radiation emitting equipment and therefore, by direction of the Governing Body/Board. Radiation Safety will be a subgroup of representatives to be included under the QI/Safety/Risk committee to report radiation safety activities. Key activities are established by the Radiation Right policies identified as CSG.MI.001 Governance and CSG.MI.003 Fluoroscopy:

- Designate an individual that is approved by MEC/GB to oversee the program
- Oversee ongoing measurement, periodic review, and improvement of key radiation safety practices and provide a quarterly report to the QI/Risk/Safety committee (Quarterly rounds)
- Periodic maintenance of equipment
- Maintaining and reviewing exposure time logs
- Communicate relevant radiation safety activities, as necessary, to the staff.
- Serve as a resource for radiation safety as it relates to staff and patient safety/regulatory issues and for the regulatory component of accrediting agencies.
- Educate staff on radiation safety practices

Infection Control

The Center conducts an annual infection control risk assessment in order to identify areas of opportunities to reduce the risk of infections (Refer to Infection Control Plan, IFC). All activities are reported through QI/MEC/GB.

Peer Review Ambulatory Surgery Centers are required by AAAHC, CMS, and other regulatory agencies to conduct quality improvement and peer review on medical staff members and allied health professionals. Peer review activities include ongoing, specialty specific review and review of variances. Peer Review will be conducted in accordance with the peer review policy and medical staff bylaws.

Confidentiality

All quality improvement and peer review activities and data are considered confidential. Any requests by outside sources for any QI, Risk management, Peer Review or credentialing information or reports will be forwarded to the appropriate HCA administrative/corporate staff when indicated.

ORGANIZATION STRUCTURE AND PROCEDURE

Role of Leadership

Leaders play a key role in facilitating improvement and ensuring a safe environment. The Sahara Surgery Center leadership includes the Governing Body, Medical Executive Committee; the facility based Medical Directors, Administrators, Risk/Quality/Safety/Radiation Safety/Infection Control designees and Clinical Managers. Leaders foster quality improvement through planning, educating, setting priorities, providing support such as time and resources, and empowering staff as appropriate.

Governing Board/Medical Executive Committee

The Board has the ultimate authority and accountability for the quality and risk programs to ensure that the quality of patient care is provided in an efficient, safe, timely and cost-effective manner. The Governing Body provides support for the improvement strategies and delegates to the Medical Executive Committee and leaderships at each facility, the authority to perform assessment and improvement activities through committees and teams. Quarterly, the Governing Body shall receive a report on the activities of the quality and risk management programs. These functions include, but not limited to:

- Assure QI/Risk/Radiation/Medication/Patient Safety is an integral part of the Center's objectives, plans and management structure
- Provide resources to support the QI/Risk/Patient Safety programs.
- Assure that improvements are sustained and evaluated for effectiveness
- Review and approve policies, reports, QI/Risk/Safety/IFC data collection and analysis, the QI/Risk/Patient Safety plans and annual evaluation.

Administration

The Center Administrator is responsible for providing qualified personnel to support the proper functioning of quality improvement and risk management activities. Administration will participate in performance improvement activities and in the assignment of priorities to the functions identified by performance improvement activities.

Key Goals:

- Assure patient care is delivered safely
- Ensure the ongoing competencies of the staff
- Support an environment that promotes process improvement, quality outcomes, reduction in risk, patient and employee safety and customer satisfaction
- Oversee reviewing and keeping current with regulatory standards (CMS,CDC, state and AAAHC)

Key Activities:

- Develop specific goals, objectives, and targets for quality improvement, risk management, infection control, as well as, radiation/medication/ patient safety.
- Designate responsibility to qualified individuals or an interdisciplinary committee for ensuring that quality and risk goals/objectives, as well as patient safety are achieved.
- Provide adequate time and training, as well as resources, for personnel to participate in quality improvement activities and to improve patient safety.
- Assure clear systems and policies/procedures for internal and external reporting of information relating to performance indicators/measures and medical/health care errors.
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors. Actively encouraging all staff to identify and report hazardous conditions and errors in a blame-free environment.
- Establish or supporting changes in processes, functions and services to sustain improved performance and to prevent recurrence and reduce risk to patients.
- Assure the effectiveness of the quality and risk management goals/objectives and contributions to improving patient safety are measured and assessed annually.

Quality Improvement/ Risk/Infection Control/Radiation Safety/Medication Safety/Patient Safety Committee

Each facility has a quality improvement committee, which derives goals from the Governing Body, Medical Executive Committee, Administration, staff and other sources. Primary responsibility of this committee is to maintain a culture of patient safety throughout all patient care processes and organizational functions. This committee is interdisciplinary and includes, but not limited to the QI/Risk/IFC Manager, Facility Administrator, Medical Director and Clinical Managers. Other members such as supervising radiologist, pharmacy nurse etc will be added to the committee as indicated by the agenda. The committee is designed to provide upper management support and direction for improvement efforts.

Key activities:

- Establish and oversee ongoing measurement, periodic review, and improvement of key processes
- Assist in identifying opportunities for improvement and participate in QI studies.
- Participate in Ambulatory Surgery Division quality, risk and patient safety initiatives including Best Practices
- Communicate relevant activities, as necessary, to the staff.
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors

- Serve as a resource for patient safety/regulatory issues and for the regulatory component of accrediting agencies.
- Provide periodic reports on quality improvement activities to Medical Executive Committee and Governing Board.
- Educate staff on quality, risk and patient safety activities

Quality Studies

Quality studies will reflect the scope of services, priorities and findings from performance monitoring or other sources. Studies will address clinical, administrative, and/or cost of care issues and will be documented in the (10) step format, which includes:

- State the purpose of the process improvement opportunity/purpose of the study
- Identify the goal of the study
- Description of data to be collected and established criteria
- Evidence of Data Collected
- Data analysis
- Comparison of actual data to goal
- Development of corrective action and execution timeline
- Re-measurement and monitoring to determine if actions have been achieved and improvements are sustained
- Development of additional corrective actions if needed
- Communication of results to appropriate personnel, MEC and Governing Board

Staff Education

The staff receives an orientation on quality improvement, risk management, infection control and patient/employee safety initiatives within 30 days of employment as part of new employee orientation. At least annually, a review of the process and accomplishments will be conducted through an appropriate mechanism. Clinical leaders will receive periodic training on any updates to initiatives, new statistical reporting or other information as indicated.

Ongoing Measurement

The Quality/Risk Manager in collaboration with the Facility Administrator and Medical Director oversees ongoing measurement. These are outlined on the addendum to this plan.

Design of New Processes

When the Center is considering a new process (for example, providing a new patient service, constructing a new facility, or redesigning an existing service), a multidisciplinary team will be convened to ensure that the process considers:

- The organization's mission, vision and strategic plans;
- Patient and community needs;
- Information about performance and outcomes of the process (including information from reference data bases).
- Current evidence based practice and research
- Current regulatory standards

Periodic Assessment and Improvement

Based on ongoing review of measurement data, this plan provides for assessment of data against historical trends and available benchmarks whenever possible. The Quality Committee, Medical Executive Committee and Governing Board review all measures quarterly.

Assessment may be triggered for any of the following:

- By any sentinel event;
- By important undesirable single events, which may include:

- “Near miss” events
 - Significant injury or death
 - Any significant untoward event during moderate sedation or anesthesia;
 - Any serious adverse drug or medication error event; and
 - Any significant hazardous condition.
 - Any significant infection control breach or trend
- By important undesirable patterns or trends, which may include:
 - Staffing effectiveness or clinical issues;
 - Any quality measure that varies substantially from an expected range; and
 - When the organization’s performance significantly varies below that of other ambulatory surgery settings or recognized standards.

Select quality data is submitted to HCA and trended with internal benchmarks across the company. This information is shared at the facility, division and enterprise level. This information is used to develop division and enterprise wide quality and risk initiatives and for external benchmarking in the ambulatory surgery arena.

In addition to ongoing measurement, the Center may at any time proactively assess its culture of patient safety as well as specific processes of care that have been identified within the healthcare industry as having the potential to harm patients. The Center may periodically assess processes using tools provided from a variety of outside sources to identify potential risks to patients and opportunities for improvement.

REFERENCED ORGANIZATIONS

AAAHc- Accreditation Association for Ambulatory Health Care, Inc., <http://www.aaahc.org/>
AHRQ – Agency for Healthcare Research and Quality, <https://www.ahrq.gov/>
CDC- Centers for Disease Control and Prevention, <https://www.cdc.gov/>
CMS-Centers for Medicare and Medicaid Services, <https://www.cms.gov/>
FDA- Food & Drug Administration, <https://www.fda.gov/>
NQF- National Quality Forum, <http://www.qualityforum.org/Home.aspx>
NPSF-National Patient Safety Foundation, <http://www.npsf.org/>
SMDA-Safe Medical Device Act, <https://www.fda.gov/MedicalDevices/Safety/ReportaProblem/default.htm>
VA Patient Safety PROGRAM, VA National Center for Patient Safety, <https://www.patientsafety.va.gov/>
WHO- World Health Organization, WHO.Int

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Revised 12/26/2018

QI/RISK GOALS for 2019

CSG/HCA Initiatives

Compliance with CSG initiatives

- Conscious Sedation Guidance
- Medication Safety-Diversion Guidebook

Clinical Safety Improvement Program 2019 Goals

1. AHRQ Culture of Patient Safety Survey results- Action Items and Implementation
2. Medical Director Engagement
3. Medication Safety-Guidebook Adoption, MDT meetings
4. SEA & Safe Table call participation

2019 Center-specific Goals

1. To continue to identify area of opportunity to reduce the IUSS rate, and to sustain the IUSS rate $\leq 10\%$ (as per HCA recommendation).
2. To comply with and meet the requirements of the 2019 Clinical Safety Improvement (CSIP) Program
3. To meet the 2019 ASD Clinical Objectives
4. Add "One Source" to Sterile Processing for immediate access to MIFU's
5. Sustain lower Direct Hospital Admission rates by continuing the current process of conducting pre-op phone call assessments and use of One Medical Passport.
6. Under the guidance of the Regional Pharmacist continue to refine the accountability process of controlled substances in the OR, PACU and Pain Departments.
7. Update the Medical Diversion program by developing a monitoring and reporting program that discourages diversion and strengthens accountability by continually seeking to improve controls.
8. Increase Risk Management in-service participation to 100%.
9. Perform one Quality Improvement Study per quarter with analysis
10. Increase reporting of Close calls with analysis for trending
11. Increase reporting of Peer Review Trending issues, continue peer review efforts with analysis for trending
12. Increase capture of patient email addresses during admission process to increase compliance with customer satisfaction surveys

Safety

SAFETY AND SECURITY

FALLS PREVENTION	1
SECURITY	2
SMOKING	3
RECALL- EQUIPMENT, SUPPLIES AND FOOD	4

HAZARDOUS MATERIALS

HAZARDOUS MATERIALS AND WASTE-INVENTORY OF HAZARDOUS SUBSTANCES	5
APPROPRIATE ATTIRE-PPE	6
HAZARDOUS MATERIALS AND WASTE-BIOHAZARDOUS WASTES – HANDLING OF BLADES, GLASS, NEEDLES, SHARPS, AND SYRINGES – HANDLING AND DISPOSAL OF	7 10
SPIILLS POLICY	12
RADIATION SAFETY	13

FIRE SAFETY

FIRE IN THE OPERATING ROOM	20
----------------------------	----

MEDICAL EQUIPMENT

ELECTRICAL EQUIPMENT - SAFE USE OF	23
ELECTROSURGICAL UNIT (ESU) SAFETY	24

MEDICAL EQUIPMENT

MEDICAL EQUIPMENT MANAGEMENT, MAINTENANCE & REPAIR	27
MEDICAL EQUIPMENT MALFUNCTION	28
USE OF DIRTY EQUIPMENT	29
SUCTIONING EQUIPMENT	30

UTILITY FAILURE

UTILITY FAILURE	31
STORAGE AND HANDLING OF MEDICAL GASES POLICY	32

FALLS PREVENTION

POLICY:

The Center's patients are at greater risk for falls when they are given anesthesia. Therefore, all patients are considered a fall risk and will be assessed to minimize their risk of falling. The Center's staff will work to actively reduce the risk of falls across the continuum of care by ensuring a safe physical environment and appropriate identification of fall risk patients.

PROCEDURE:

Standard Fall Risk Interventions:

- a. Orient patient/family to environment and routines.
- b. Ensure that patient bed is in low position and the brake is on.
- c. Place patient's necessary items within reach.
- d. Provide non-skid footwear for patient as needed.
- e. Minimize environmental trip/slips hazards.
- f. Round frequently (approximately every hour) and assess for safety and comfort.

Reporting Patient Falls:

Patient falls must be reported through the standard incident reporting process as patient falls are identified as an Incident.

SECURITY

POLICY

The Governing Body is responsible for creating a suite that can be secured. The Clinical Supervisor is responsible for ensuring that the suite is secure throughout the day and after each surgical day.

PROCEDURE

1. The number of people with access shall be kept to a minimum. Only those employees *requiring* access will be issued keys. The Administrator is responsible for all keys/authorization.
2. Emergency assistance can be summoned by calling the front desk from any phone, or dialing 911 for fire or police assistance. In addition, direct emergency numbers are included on the Emergency Phone List.
3. Signs will be posted "Authorized Personnel Only" leading into the recovery and reception area.
4. All visitors shall check in the reception area. The receptionist will notify the appropriate personnel.
5. The Center will control and identify security sensitive areas to prevent all unauthorized entries.
6. During hours of non-operation, security is provided by a monitored security system.
7. A keypad will be utilized to arm and dis-arm the security system. The Clinical Supervisor is responsible for ensuring that the system is armed at the end of each day and dis-armed at the beginning of each day. The Clinical Supervisor is also responsible for ensuring that appropriate staff know how to arm and dis-arm the security system.

SMOKING

POLICY:

The Center is a smoke-free facility and does not permit smoking or vape smoking inside the facility or near any entrances to the facility. There shall be signs posted throughout the center to inform the staff, patients and visitors of our “NO SMOKING” policy.

PROCEDURE:

1. Management personnel are responsible for enforcing the no smoking policy of the Center.
2. Employees are informed of the Center’s policy at time of hire.
3. Management personnel are responsible for ensuring that the No Smoking signage remains posted and visible to staff, patients and visitors.

RECALL- EQUIPMENT, SUPPLIES AND FOOD

OVERVIEW

A recall is a method of removing or correcting products that are in violation of laws administered by the Food and Drug Administration (FDA). Recall is a voluntary action that takes place because manufacturers and distributors carry out their responsibility to protect the public health and well-being from products that present a risk of injury or gross deception or are otherwise defective.

POLICY

There shall be a policy and procedure in place to ensure that the Center does not utilize any recalled or discontinued, medical devices, equipment and supplies or food products. In addition, there shall be a mechanism whereby the Center locates recalled or discontinued equipment, supplies and food products. When the Center is notified (e.g., by the manufacturer or FDA) of such a recall for an item it is not to be utilized for safety reasons and the Center is to notify the appropriate individuals and organizations regarding the notification, if appropriate (ie, the item has been used beyond the date of the recall).

PROCEDURE

1. The Clinical Supervisor will register with FDA Recalls & Alerts website to monitor any notifications.
2. When a notice is received from the FDA or the manufacturer that, for safety reasons, the specific item should be not utilized:
 - a. The notice shall be forwarded to the Clinical Supervisor
 - b. The Clinical Supervisor will check to see if the equipment or supplied was utilized at the Center.
 - c. If the equipment or supply listed is/was used, the Clinical Supervisor shall refer to the inventory list to determine if the recalled/discontinued item matches the recall listed in the notification. If it does not match, no action need be taken.
 - d. If there is a match, the Clinical Supervisor shall notify the Medical Director and take the following action:
 - i. If there is any existing stock of the recalled/discontinued item, the Clinical Supervisor shall follow the directions of the notification.
 - ii. If the recalled/discontinued item was utilized, the Clinical Supervisor will notify members of the medical staff regarding the recall.
 - iii. If the notification instructs that patients are to be notified, the Clinical Supervisor is responsible for ensuring that medical records are reviewed and patients notified in the manner prescribed.

HAZARDOUS MATERIALS AND WASTE-INVENTORY OF HAZARDOUS SUBSTANCES

POLICY:

An inventory of all known hazardous substances used in this Center shall be kept in a location known to all employees. All hazardous materials shall be identified and labeled with hazard warnings according to the Centers Hazard Communication Program. (Please refer to Hazard Communication Program/OSHA Manual)

Specific information on each noted hazardous substance can be obtained by reviewing the Material Safety Data Sheet for that substance.

NOTE: The Center shall have all the required permits, licenses, manifests, and safety data sheets required by law and regulation for managing hazardous materials and waste.

APPROPRIATE ATTIRE-PPE

POLICY

There shall be a standardized policy of what attire shall be worn for specific tasks. Staff shall be informed of specific personal protective equipment (PPE) to be worn for specific tasks involving blood or hazardous waste.

PROCEDURE

1. Staff shall be aware of the location of all PPE items (gloves, gowns, face shields).
2. Staff shall be provided appropriate training regarding the use of all PPE.
3. Specific PPE shall be donned during the performance of tasks involving blood, hazardous material or potentially hazardous materials according to the table below:

Task	PPE Item(s)
Instrument cleaning	Protective Gown Gloves Face Shield
Cleaning of spills	Protective Gown Gloves Face Shield
Cleaning of the Surgical Suite while using toxic cleaning agents (virucidal, fungicidal, bleach)	Protective Gown Gloves Face Shield
Using glutaraldehyde	Protective Gown Gloves Face Shield
Disposal of Biological Waste	Protective Gown Gloves Face Shield
During Surgery	As appropriate for the procedure: Protective Gown Gloves Face Shield

HAZARDOUS MATERIALS AND WASTE-BIOHAZARDOUS WASTES – HANDLING OF

BACKGROUND AND DEFINITIONS

This Center must comply with all state and federal regulations regarding handling and disposal of waste. Depending on the classification of the Center (“large volume” or “small generator”), there will be different regulations and reporting requirements.

Biohazardous waste, also called infectious waste or biomedical waste, is any waste containing infectious materials or potentially infectious substances such as blood. Of special concern are sharp wastes such as needles, blades, glass pipettes, and other wastes that can cause injury during handling.

Biohazardous waste includes the following materials:

1. **Human blood and blood products:** All human blood, blood products (such as serum, plasma, and other blood components) in liquid or semi-liquid form. Items contaminated with blood that, if compressed, would release blood in a liquid or semi-liquid form, or items caked with dried blood capable of being released during handling. Other body fluids or tissues containing visible blood.
2. **Human Body Fluids:** Human body fluids in a liquid or semi-liquid state, including: semen, vaginal secretions, cerebral spinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid and saliva from dental procedures. Also includes any other human body fluids visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.
3. **Pathological waste:** All human tissues, organs, and body parts, including waste biopsy materials, tissues, and anatomical parts from surgery, procedures. Any unfixed human tissue, except skin.
4. **Sharps waste:** Sharps waste must be packaged as described in Sharps policy.

Responsibilities of Biohazardous Waste Generators

Surgery centers that generate biohazardous waste are responsible for:

1. Ensuring that the waste is properly packaged and transferred to the contracted hazardous waste hauler;
2. Packaging the waste as directed to prevent exposure or injury (needlesticks, cuts) to anyone handling the waste; and
3. Packaging the waste in the appropriate packaging (sharps in sharps containers, other waste in red bags).

Biohazard Waste Minimization

Although biohazard waste bags are often conveniently placed throughout the Center, it is important to remember that these bags are for **biohazard and contaminated wastes only**, and are not to be used for regular trash. Disposal of non-biohazard waste in a biohazard waste container adds significant costs to waste management.

The following are examples of items that do **not** need to be disposed as biohazard waste:

1. Gloves used to handle containers of blood or body fluids;
2. Paper towels or bench paper on which containers of blood or body fluids may have been placed but did not spill; and
3. Any other material used to handle blood indirectly but that did not come into direct contact with the blood.

BIOHAZARDOUS WASTES - HANDLING OF

Page 2

POLICY:

1. There is to be a standardized, safe and effective method for disposing of bio-hazardous waste.
2. All bio-hazardous waste shall be handled and packaged appropriately while ensuring that proper labeling is present for the containers or bags and the areas that house these wastes.
3. All personnel shall be informed of the proper methods for handling bio-hazardous waste through periodic inservices.
4. **Universal/Standard precautions must be adhered to at all times which includes the required use of eye protection, barrier materials and gloves when handling bio-hazardous materials, including bags and tubs**

PROCEDURE:

1. Wastes are accumulated in those containers with a red bag insert. Only those waste materials deemed appropriate shall be placed in the red bags (see Sharps policy for sharps handling and disposal).
2. Red bags and their contents are then transferred to the biohazardous waste storage area in the designated containers (that are labeled).
3. The biohazardous wastes pick-up company will then pick up these wastes regularly (as frequently as required, see agreement).

BIOHAZARDOUS WASTES - RED BAG CONTENTS

(WHAT MUST I PUT INTO THE RED BAG?)

The following materials are to be placed in the Red Bags for pick-up by the biohazardous waste company.

- I. **INFECTIOUS WASTE:** This includes any disposable item that has been soiled by any bodily fluid of the patient and would include such items as:
- | | |
|------------------------|--|
| Surgical Gloves | Waste from Isolation Rooms |
| Dressings and Packings | Suction Tubing |
| Swabs | Laboratory Wastes: |
| Specula | -Culture Dishes |
| Soiled Gowns | -Pasteur Pipettes* |
| Drapes | -Vacutainers & other vials contaminated by specimens* |
| | -Slides* |
| | -Lancets* |
| | -Capillary Tubes* |
| Catheters & Canulae | -Discarded live & attenuated vaccines |
| | -Any residual specimen from medical or pathological laboratories |

II. **SHARPS:**

Used hypodermic equipment (including syringes)
Scalpel blades
Lancets
Suture needles
Broken glass
Pipettes
Any item in other category marked with *

Sharps MAY NOT be placed directly into a Red Bag. They must be deposited into leakproof, rigid, puncture resistant containers that are tightly lidded or taped closed prior to being put into Red Bag containers.

Universal precautions must be adhered to at all times which includes the required use of eye protection, barrier materials and gloves when handling bio-hazardous materials, including bags and tubs.

BLADES, GLASS, NEEDLES, SHARPS, AND SYRINGES – HANDLING AND DISPOSAL OF

This policy is designed to meet all state, city and county regulations and to protect all staff who are at risk in the handling of waste sharps. Procedures for non-sharp waste (e.g., non-sharp infectious, chemical, radioactive, unbroken glassware, and non-hazardous waste) are not affected by this policy.

DEFINITION:

Sharps include:

1. Needles (whether or not attached to a syringe or covered by a plastic guard);
2. IV tubing with needle attached;
3. Glass slides and cover slips;
4. Scalpels, razor blades, and lancets; and
5. Broken glass and splintered plastic, *when contaminated with blood or other potentially infectious material.*

Non-contaminated broken glass and plastic are NOT considered sharps for disposal purposes.

SHARPS WASTE MINIMIZATION:

Although sharps containers are often conveniently placed throughout the Center, it is important to remember these containers are for **sharps waste only**, and are not to be used for non-sharp biohazard waste or regular trash. Disposal of non-sharp biohazard waste in a sharps container adds significant costs to waste management.

The following are examples of items that should **not** be disposed of as sharps waste:

1. Gloves;
2. Paper towels;
3. Plastic vials and conical tubes;
4. Pillow covers, paper sheets

SHARPS WASTE DISPOSAL PROCEDURES:

Sharps are collected in standard sharps containers. These sharps containers are available in multiple sizes.

The **standard (non-chemical) sharps waste** pickup procedure is as follows:

1. When sharps container is 2/3 to 3/4 full, secure the lid. At no time shall containers be filled past the "fill line".
2. Place the sharps container in the appropriate location (with the biohazard label) for pickup by the contracted purveyor.

POLICY:

One of the greatest causes of skin punctures in the Operating Room is careless handling of needles left on syringes and surgical blades left on handles.

1. Any syringe with a needle that is used by personnel should be properly placed in the designated receptacle for needles and syringes. Needle caps must never be re-placed on the needle on the syringe.
2. Any syringe with a needle that is used on the sterile field should be disposed of at the end of the surgical procedure.
3. All used needles, blades and syringes shall be placed in the designated containers throughout the Center.

BLADES, GLASS, NEEDLES, SHARPS, AND SYRINGES – HANDLING AND DISPOSAL OF

Page 2

PROCEDURE:

1. When finished with syringes and needles, place them into the designated plastic container. ***Never re-cap any used needle or any syringe.***
2. Place closed needle and syringe containers in the appropriate, labeled receptacles.
3. Emptied glass bottles are to be discarded in regular trash containers if they do not contain chemicals.
4. All sharps are to be put into an appropriate, puncture-resistant, labeled container.
5. At end of the procedure, all blades, needles and sharps are disposed of in the manner described previously. Infectious waste will be stored in the infectious waste container and will be picked up regularly by the bio-hazardous wastes pick-up company. See “Red Bag Contents” policy for those items that should be placed in the red bags and in hazardous waste containers.

SPILLS POLICY

PURPOSE:

1. To prevent spread of infection through the Center and to maintain an aseptic environment.
2. To provide a safe environment for both patients and staff members, and provide protection from possible injury or exposure to hazardous material.

POLICY:

Any staff member who spills fluid or witnesses a spill in the Operating Room or perioperative areas shall adhere to the following procedures.

PROCEDURE:

1. Any staff member who spills fluid or the first staff member to see a spill on any surface of the facility shall first notify all personnel in the immediate area of the spill and warn them of its location.
2. The staff member shall then notify the Clinical Supervisor of the spill. The Clinical Supervisor shall inspect the spill site and determine whether the spill should be considered toxic or hazardous according to OSHA SDS standards. Should the spill be determined to be hazardous or toxic according to SDS standards, the disposal and ventilation procedures contained in the SDS manual shall be followed. **THE MSDS MANUAL SHALL BE AVAILABLE AT ALL TIMES IN THE CENTER AS A REFERENCE.** The spill shall be handled in accordance with the Material Safety Data Sheet. If the spill contains, or may contain, body fluids, the spill shall be cleaned with a germicide, observing Universal/Standard Precautions and donning personal protective clothing and disposing of the disposable cleaning materials in the red bags and re-useable materials in the soiled linen container.
3. If the spill is determined by the Clinical Supervisor to be environmentally hazardous or toxic to staff and/or patients in the immediate area, evacuation procedures shall be initiated as outlined in the Safety Section of the Policies & Procedures.
4. **ALL SPILLS SHALL BE CONSIDERED POTENTIALLY INFECTIOUS AND UNIVERSAL PRECAUTIONS ADHERED TO AT ALL TIMES.**

In the presence of large blood spills, an EPA-registered disinfectant or a 1:10 final dilution of EPA-registered hypochlorite (bleach) solution initially should be used to inactivate bloodborne viruses to minimize risk for infection to health-care personnel from percutaneous injury during cleanup.

Reference: CDC Sterilization and Disinfection in Healthcare Facilities, 2008

5. The Clinical Supervisor shall assign an appropriately trained staff member to the clean-up of the spill. The Staff member shall first carefully observe the area for any sharps or broken glass material which may cause injury during clean-up. This material shall be disposed of according to the Red Bag Policy on sharps.
6. Any applicable SDS procedures shall be reviewed and followed. In the absence of applicable SDS procedures, the staff member shall proceed to clean the area with appropriate germicide and hot water as outlined under the Terminal Cleaning Policy.
7. If the spill contains bodily fluids, or *may contain* bodily fluids, the spill shall be cleaned with a mop and germicide. After the mop is used for this purpose, it shall be placed in a red bag for disposal with other hazardous waste.
8. If the spill area is a floor space where there is ongoing traffic and the area remains wet, the area will be cordoned off with "Wet Floor" warnings to other personnel. The area shall be checked regularly until it is dry and warnings can then be removed.
9. The Clinical Supervisor shall inform the janitorial service of the area of the spill, and ask that it receive added attention during regular cleaning service

RADIATION SAFETY

Purpose:

To provide a safe environment for patients, physicians and employees during fluoroscopy procedures in accordance to state law and regulations.

Policy:

A licensed X-Ray Tech may operate or direct operation of fluoroscopy equipment.

1. Radiologic Technologists shall not independently perform diagnostic fluoroscopic procedures for the purpose of interpretive diagnosis. Fluoroscope for diagnosis is performed, by a licensed X-Ray Tech.
2. If a nurse or surgical tech does not possess a fluoroscopy certificate or permit, they may only do the following under the supervision of the licensed operator:
 - Place the patient on the table,
 - Move the C-Arm from storage to the operating room and move the equipment over the patient,
 - Plug in and turn on the power for the fluoroscopy unit

The supervisor shall ensure that radiation safety activities are being performed in accordance with approved procedures and regulatory requirements in the daily operation. The supervisor's specific duties shall include:

- Establishing and overseeing operating and ALARA (As Low As Reasonably Achievable) procedures.
- Ensuring that radiation operations are conducted safely and assuming control and authority to institute corrective actions.
- Ensuring that the patient will be protected from unnecessary radiation exposure.
- Ensuring that measures will be taken to protect patients during the procedure from the risks of direct and indirect radiation exposure. Any direct or indirect radiation exposure will be documented in the health care record.

Procedure:

Protecting the Patient from Unnecessary Exposure

- Care will be taken to keep extraneous patient body parts out of the radiation beam to prevent injury.
- Before any radiological exposure, female patients of childbearing age will be questioned about the possibility of pregnancy.
 - If the possibility of pregnancy exists, the surgeon will be notified to determine the advisability of continuing or postponing the procedure.
- Signs will be posted throughout the Center.
- Lead shielding will be placed between the patient and the source of radiation whenever possible to reduce unintended radiologic exposure.
- Lead shielding will not be in the beam during procedures using fluoroscopy (eg, hand surgery).
- Lead shielding will be used, when possible, to protect the patient's ovaries or testes during x-ray studies, including those performed on the hips and upper legs.
- Lead shielding will be used, when possible, to protect the patient's thyroid during x-ray studies of the upper extremities, trunk, and head.

Minimizing Occupational Exposure

- The fluoroscopy equipment shall be located in a restricted area. The restricted area is designated by "Caution X-Ray" signs.
- Only authorized personnel are allowed in the room during fluoroscopy examination.
- Warning signs must be posted to alert health care personnel to potential radiation hazards at entrances to ORs and other procedure rooms where radiological equipment is in use in accordance with Title 17.
- Health care personnel will limit the amount of time spent in close proximity to the radiation source when exposure to radiation is possible. The radiation equipment operator must notify personnel present in the treatment room before activating the equipment.
- During fluoroscopic procedures, health care personnel will keep the patient as close as possible to the image intensifier side of the fluoroscopic unit and away from the tube side of the unit.
- Health care personnel involved in fluoroscopic procedures will stand on the image intensifier side of the fluoroscopic unit, whenever possible, to reduce exposure (ie, standing on the same side as the image intensifier experience decreases radiation intensity). Minimize fluoroscopy exposure time and use pulse exposure whenever necessary or possible adhering to the principles of ALARA.
- Health care personnel assisting with radiological procedures will not hold the patient manually for a radiographic study because of the risk of direct beam exposure.
- Shielding will be available at all times when radiation is being delivered to the health care personnel who may be potentially exposed. The following shielding will be available:
 - aprons and thyroid shields,
- Health care personnel who may have to stand with their backs to the radiation beam will wear wrap-around aprons to decrease the risk of exposure.
- Health care personnel near the radiation beam (eg, oblique imaging with the x-ray tube in close proximity to the lower body of the operator) will wear aprons of sufficient length to shield the upper legs and protect the long bones and bone marrow from increased doses of radiation.

- Thyroid shields will be worn by health care personnel to protect the thyroid whenever the likelihood of the procedure (eg, orthopedic spinal fixation procedures) places them at higher risk because of increased exposure.
- Female health care personnel will protect their breasts from radiation exposure by using aprons that cover the area completely.
- Health care personnel will keep all body parts out of the direct x-ray beam.

Pregnant Health Care Personnel

- Health care personnel will not be required to disclose pregnancy, even if their condition is obvious; however, personnel are strongly encouraged to declare this condition to the Clinical Supervisor. In accordance with Title 17, the following will occur:
 - The healthcare worker will be reassigned during the pregnancy and will not be allowed in the OR when the fluoroscopy is in use.

Radiation Monitors

- Health care personnel who are involved routinely in fluoroscopic procedures will wear at least one radiation dosimeter badge.
- The monitors will be read on a quarterly basis. Results will be reviewed to ensure staff has not exceeded the occupational dose limits.

Documentation

- Any x-ray procedure performed in the operating room must be documented in the fluoroscopy log.
- The Center will provide documentation of records such as Notice to Employees posting and Notice of Registration.
- An incident report will be completed wherein the procedures and interventions in this policy were not followed where unintended radiological exposure occurred.
- Documentation of the readings of the dosimeters will be provided on, at least, a quarterly basis and maintained by the Center.
- Records of the provisions of the radiation safety program (including personnel radiation exposure monitoring records) will be maintained at this facility until the registration is terminated. Records of audits and other reviews of program content and implementation will be maintained at the facility for three years after the record was created.

Shielding Devices

- Before use, newly purchased leaded devices will be tested for any cracks and for shielding properties to ensure no damage (eg, cracks or holes) occurred during transit.
- Leaded aprons and thyroid shields will be stored flat or hung vertically and will not be folded.
- Protective devices will be cleaned with an EPA-registered disinfectant after every use.

These procedures have been developed to ensure safe radiological working conditions. Everyone must adhere to these procedures. In-services regarding Radiation Safety will be conducted on an annual basis.

Spacer Cone

The spacer cone of the fluoroscopy unit shall never be removed. If, the spacer cone is requested to be removed the following must be implemented:

- A list of procedures shall be approved by the Governing Body for which the physician deems necessary for the spacer cone be removed.
- The manufacture’s published precautions shall be available with respect to the spacer cone.
- All physicians and fluoroscopy personnel shall receive training regarding the spacer cone use and restrictions. Documentation of training shall be maintained for inspection.
- The spacer cone shall be reinstalled upon completion of the examination(s) for which removal is authorized.

These procedures have been developed to ensure the safe radiological working conditions. Everyone must adhere to these procedures. In-services regarding Radiation Safety will be conducted on an annual basis.

References: Recommended practices for reducing radiological exposure in the perioperative practice setting. In: Perioperative Standards and Recommended Practices. Denver, CO: AORN, Inc; 2013:295-

The personnel exposure policy shall be reviewed on a regular basis and exchange on a specific time frame. Each individual shall be aware of their accumulated dose. If the dose exceeds the dose limit, the facility must report the dose to the supervisor, and promptly take appropriate corrective action to ensure against recurrence. This corrective action may include reassigning personnel duties. The Clinical Supervisor shall notify the National Council of Radiation Protection (NCRP) Section as required if any of the following annual regulatory exposure limits are exceeded:

ANNUAL OCCUPATIONAL DOSE LIMITS

Total Effective Dose Equivalent [TEDE] Sum of deep-dose equivalent [DDE, WB] for external exposures and total organ dose equivalent [TODE] for internal exposures, to the whole body [head/neck/torso region of the body]	5,000 mrem
OR	
Total Organ Dose Equivalent [TODE] Sum of deep-dose equivalent [DDE] and committed dose equivalent [CDE] to any single organ or tissue other than the lens of the eye	50,000 mrem
Skin [SDE, WB and SDE, ME]	50,000 mrem
Lens of the Eye [LDE]	15,000 mrem
Embryo/Fetus (Declared Pregnant Women)	500 mrem
Minors	500 mrem
General Public	100 mrem

FIRE SAFETY-FIRE IN THE OPERATING ROOM

GENERAL INFORMATION

Because of the presence of oxygen in the operating room, the potential for a dangerous fire is constantly present. A fire may be started by a spark from a cautery, from a suddenly malfunctioning piece of equipment or another source. The presence of oxygen means that this spark may be instantly amplified to a fire which will endanger the patient, surgeon and all medical staff.

POLICY

1. All medical staff shall be aware of and trained in the dangers of operating room fires and how to reduce the potential of operating room fires.
2. Physicians shall be advised of the danger of operating room fires and aware of ways to reduce the potential of operating room fires.
3. Precautions shall be taken for every case, every day to reduce the potential of operating room fires.
4. Inservices shall be held to educate Medical staff on the preventive measures used to reduce the risk of oxygen-aided fires in the operating room.
5. As part of the orientation program, the Clinical Supervisor and/or the Medical Director shall educate new employees in the dangers of operating room fires and inform them of ways to reduce the risk of these oxygen-aided fires.
6. Because of the constantly changing and advancing field of operating room instrumentation and because of the importance of this issue, Inservices for the medical staff shall be held at regular intervals (at least annually) to re-educate staff on the constant danger of these fires, ways to reduce the risk and ways of fires occurring and how to recognize potential causes

PROCEDURE

During head and neck procedures particular attention must be given to prepping, draping and positioning the patient, as patients with their heads draped are more susceptible to fire because supplemental oxygen can accumulate under the drapes. To decrease the risk of fire, the prep solution must be given adequate time to dry (3 minutes) - especially if there is alcohol in the solution. Draping and positioning the patient should be performed in a manner that does not allow pooling of oxygen under the drapes. Every effort should be made to use no more oxygen than is necessary to maintain adequate oxygen levels. If possible, provide room air or less than or equal to 30% oxygen, depending on patient needs. Oxygen can also be combined with air to decrease the risk of fire. If facial hair is exposed, coat the hair with a water-soluble surgical lubricating jelly to make it nonflammable. Additionally, moisten sponges, gauze and pledgets (and their strings) to render them ignition resistant. This is also true for chest procedures, where oxygen may pool in the open body cavity.

During all procedures, as a proactive safety measure, sterile water or saline must be on the back table prior to ESU, argon beam coagulator (ABC) or lasers being used. Additional

safety measures that should be taken when performing electrosurgery, electrocautery or laser surgery are as follows:

- Stop supplemental O2 at least one minute before and during use of the unit, if possible. (Surgical team communication is essential.)
- Activate the unit only when the active tip is in view, especially if looking through a microscope
- Deactivate the unit before the tip leaves the surgical site
- Place electrosurgical electrodes in a holster or another location off the patient when not in active use (i.e., when not needed within the next few moments)
- Place lasers in standby mode when not in active use
- Do not place rubber catheter sleeves over electrosurgical electrodes

Fiberoptic Light Sources

Fiberoptic light sources can start fires. Complete all cable connections before activating the source. Place the light source in standby mode, or turn the unit off when disconnecting cables. Never leave a light cord that is still luminating on top of the patient drapes. Although surgical drapes are fire retardant, they are still flammable.

In Case of a Fire in operative or procedural areas the following steps should be taken in order initiate RACE:

1. Announce the fire.
2. Remove the burning material from contacting the patient (drapes, ETT, etc.)
3. Have the anesthesiologist stop the flow of gases (i.e., O2, N2O, Desflurane, etc.)
4. Immediately smother/put out the fire (when safe to do so).
 - Attempt to extinguish with water or saline aim at the base of the fire.
 - To smother a fire hold a towel between fire and the patients airway, drop one end of the towel toward the patients head, drop the other end of towel over the fire, sweep your hand over the towel and raise the towel and keep your body away from the fire. **DO NOT PAT** the fire.
 - Obtain fire extinguisher as last response and Extinguish on floor.
5. Set off the fire alarm (Code Red)
6. Evacuate the patient, if necessary
7. Save any material/devices for follow-up investigation

Fighting Fires Involving an Endotracheal Tube

1. Announce the fire.
2. Collaborate and assist the anesthesia professional with:
 - disconnecting and removing the breathing circuit
 - turning off the flow of oxygen
 - pouring saline or water into the airway
 - removing the endotracheal tube and any segments of the burned tube
 - examining the airway
 - re-establishing the airway

Fighting Fires On or In Equipment

1. Communicate the presence of the fire to team members.
2. Disconnect equipment from its electrical source.
3. Shut off electricity to the piece of equipment at the electrical panel.

4. Shut off gases to equipment, if applicable.
5. Assess fire size and determine if equipment can be removed safely or if evacuation is needed.
6. Extinguish fire with extinguisher, if appropriate
7. Activate alarms, if necessary.
8. Notify the appropriate personnel.

Reference: Fire Prevention in the Perioperative Practice Setting 2013

FIRE SAFETY-FIRE WATCH/SYSTEM IMPAIRMENT

PURPOSE

To provide a mechanism for monitoring a building or portions of a building for potential or actual fire and smoke conditions during fire protection system shutdown or operational failure.

CAUSES

Fire alarm system or sprinkler system outages can occur during construction, maintenance, renovation, electrical storms, heat waves that cause overloads, brown-outs or other unplanned events which eliminate part or all of the fire alarm system. The sprinkler system may also be made inoperable by a variety of planned or unplanned events.

POLICY

There shall be a policy and procedures in place to protect the safety of the Center's staff, patients and visitors as well as the physical facility in the unlikely event that the fire alarm or sprinkler system is out of order for an extended period of time (greater than ten hours).

PROCEDURES

I. Implementation

- A. In the event that the fire alarm system or sprinkler system must be shut down by the building or is out of service due to unforeseen circumstances, the fire protection system impairment policy will be implemented.
- B. Upon notification or identification of a system outage that is anticipated to last more than four hours in a 24 hour period, the following fire watch procedures will be initiated:
 1. The Medical Director will notify the local Fire Department to alert them to the condition.
 2. The Clinical Supervisor will notify the fire alarm monitoring company of the situation.
 3. The Medical Director (or Clinical Supervisor in his/her absence) will conduct the fire watch. Fire watch tours shall be conducted every 15 minutes until the source is identified or the system reinstated. The Medical Director shall be solely dedicated to fire watch duties and not perform any other Center-related activities.
 4. A patrol of the area shall be performed by the Medical Director. During the patrol of the area, the fire watch procedure should not only be looking for fire or hazardous conditions which could start a fire, but ensure that the other fire protection features of the building such as egress routes and any other fire protection systems are available and functioning properly.
 5. Fire watch inspection tour should check and document the following:
 - Mechanical and Electrical rooms – remove all combustible or flammable materials.
 - Access – ensure that the fire department can reach the building and entrances are not blocked.
 - Exit access – All exit pathways are unobstructed
 - Fire/Smoke separations – All fire and smoke doors are closed properly.
 - Machinery unnecessary to be run continuously is turned off.
 - Any construction or renovation work is halted.
 - Fire extinguishers are charged and unobstructed

- C. If a fire or smoke condition is identified, RACE (Rescue/Alarm/Contain/Extinguish/Evacuate) will be initiated and the Medical Director will notify the local Fire Department.
- D. If there is a fire behind a door:
 - DO NOT OPEN THE DOOR
 - Touch door handle and door frame and verify raised temperature.
 - Smell for smoke or fumes
 - Implement RACE program
 - Remove patients from immediate danger and evacuate the building, if possible.
 - Activate a call to the local fire department (9-1-1).
 - Contain fire by shutting doors ONLY IF YOU CAN SAFELY DO SO
 - Extinguish fire ONLY if it is small (small trash can). Otherwise, evacuate the area.

II. Closeout

- A. The local fire department will determine if there is a need to extend the fire watch into the following day.
- B. During routine construction and maintenance system outages, every effort will be made to accomplish work within the operational shift period so that the need for fire watch won't exceed an 8 hour period, re-enabling the system(s) for the off-shift.
- C. When the system is restored to normal operation, a Fire Marshal will close out the system impairment and confirm that the fire watch activities may be discontinued.

MEDICAL EQUIPMENT- ELECTRICAL EQUIPMENT - SAFE USE OF

POLICY:

All electrical equipment must be used in a safe and orderly fashion. All electrical wires on equipment must be in a good and proper order, have no frayed ends or uncovered wires, broken plugs, etc. Any observation of this should be reported to the physician immediately, and immediate repairs undertaken.

PROCEDURE:

1. Only standard and UL approved electrical plugs should be put in any electrical outlet.
2. All electrical outlets in the operating room(s) must be hospital grade and be checked for proper polarity and adequate grounding. All equipment fittings shall be hospital grade.
3. Always grasp electrical wiring on the plug head itself when pulling a plug out of a receptacle to avoid breaking the wire. Never pull on the wire itself.
4. Any evidence of shorting of equipment should be reported immediately to the surgeon and Clinical Supervisor.
5. Flashlights will be available.

MEDICAL EQUIPMENT - ELECTROSURGICAL UNIT (ESU) SAFETY

POLICY:

All personnel will follow safety guidelines in order to reduce the potential for injury to the patients, surgeons and employees who use cautery equipment.

PROCEDURE:

- A. The ESU, dispersive electrode and active electrode shall be used according to the manufacturer's written instruction.
- B. Perioperative personnel will be instructed in the proper operation, care and handling of the ESU during their orientation period. Return demonstration after instruction must be documented for the perioperative employee.
- C. The ESU must be inspected before each use and checked at least annually by the biomedical service.
- D. Damaged or malfunctioning ESUs must be removed immediately and reported to the management.
- E. The ESU shall be assigned an identification number. The identification/serial number of the ESU is to be documented on the OR record.
- F. To prevent injury, patients will be instructed to remove as much jewelry as possible before their surgical procedure.
- G. The ESU shall be used in a manner that reduces the potential for injuries.
 1. Following use, the ESU shall be turned off and the unit and all its reusable parts cleaned according to the manufacturers written instructions. The surface of the ESU shall not be saturated with or have fluids poured over it.
 2. The ESU shall not be used in the presence of flammable agents (e.g., alcohol, tincture-based fluids)
 3. Safety features (e.g., lights, activation sound indicator) shall be present and tested before each ESU use.
 4. Power settings shall be confirmed verbally between the operator and the user before activation and determined in conjunction with the manufacturers written recommendations and the patients' size.

The ESU shall be operated at the lowest effective power setting to achieve the desired effect for coagulation and cutting. Personnel shall check the entire ESU circuit if the operator requests a continual increase in power because of ineffectual usage results.
 5. The ESU shall be protected from spills. Fluids shall not be placed on top of the ESU.
- H. The ESU active electrode shall be used in a manner that minimizes the potential for injuries.
 1. The active electrode shall be connected directly into a labeled, stress-resistant receptacle of the ESU. If an adapter is used, it shall be one that is approved by the manufacturer and does not compromise the generator's safety features.

2. The active electrode shall be inspected for damage, including impaired insulation, at the operative field before use.
 3. The active electrode shall be placed in a clean, dry, well-insulated safety holster when it is not in use.
 4. The active electrode shall be disconnected from the ESU and replaced if it drops below the sterile field.
 5. The active electrode shall have a tip that is secure and easy to clean.
- I. The dispersive electrode shall be used in a manner that minimized the potential for injuries.
1. The patient's skin integrity shall be evaluated and documented before and after ESU use.
 2. The dispersive electrode shall not be placed over bony prominences, scar tissue, skin over an implanted metal prosthesis, hairy surfaces, or areas distal to tourniquets and pressure points.
 3. The dispersive electrode shall be the appropriate size for a patient (i.e., neonate, infant, pediatric, adult) and never be cut to reduce its size.
 4. After positioning the patient, the dispersive electrode shall be placed on a clean, dry skin surface over a large, well-perfused muscle mass and as close to the operative site as possible.
 5. Patients' jewelry shall be removed.
 6. Excessive hair shall be removed before applying the dispersive electrode.
 7. The dispersive electrode shall connect directly into a labeled, stress-resistant receptacle of the ESU. If an adapter is used, it shall be approved by the manufacturer and not compromise the ESU generator's safety features.
 8. The dispersive electrode shall maintain uniform body contact to avoid tenting, gaping, and moisture that interferes with complete adhesion with the patient's skin.
 9. The dispersive electrode shall be removed carefully to avoid denuding the surface of the skin.
 10. The dispersive electrode and its connection to the ESU shall be checked if any tension is applied to the dispersive electrode cord or if the surgical team repositions the patient.
- J. Bipolar active electrodes function differently than monopolar active electrodes and shall be used according to the manufacturers written instruction.
1. In bipolar electrosurgery, a forceps is used for the coagulation of body tissue. One side of the bipolar forceps is the active electrode, and the other side is the return or ground electrode.
 2. A dispersive electrode is not needed because current flows between the two tips of the bipolar forceps rather than through the patient.

Reference AORN Standards, Recommended Practices and Guidelines (1999, 2000)

- 1 Use of the ESU with an operating laparoscope requires personnel to:
 - Examine all electrodes for impaired insulation before use,
 - Ensure proper connection of equipment,
 - Ensure that the active electrode is not activated until it is in close proximity to the tissue,
 - Use the low-voltage cutting wave form setting whenever possible,
 - Avoid open-circuit activation of the active electrode,
 - Use the lowest power setting that achieves the desired result, and
 - Use all metal or all plastic cannulas and not a hybrid cannula system (i.e., a combination of plastic and metal cannulas).
- L. If patient or personnel injuries or equipment failures occur, the ESU and the active and dispersive electrodes shall be handled in accordance with the Safe Medical Devices Act of 1990.
- M. Personnel shall take special precautions when using the ESU with patients who have pacemakers and/or automatic defibrillators.
 1. Patients with pacemakers shall have continuous ECG monitoring during ESU use.
 2. Patients with an automatic implantable cardioverter/defibrillator (AICD) shall:
 - Have the AICD device deactivated before the ESU is activated
 - Have a defibrillator immediately available, and
 - Have continuous ECG monitoring.
- N. Exposure to smoke plume generated during electrosurgery shall be reduced.

MEDICAL EQUIPMENT MANAGEMENT, MAINTENANCE & REPAIR

POLICY:

1. Each piece of operating room and recovery room equipment shall be checked prior to any procedures commencing. This is to ensure proper operation of the equipment and reduce the possibility of malfunction and/or injury to patients or staff during any procedure or the recovery period.
2. Equipment used by the Center for the provision of patient care shall be maintained and serviced only by a contracted bio-medical company approved by the Governing Body.
3. All equipment be properly maintained so that it functions as intended and that services for maintenance and repair be obtained in a cost effective and timely manner.
4. The Center shall have documentation of the pre-cleaning, transport, and handling of medical devices intended for external vendor reprocessing, inspection, or repair.

PROCEDURE:

1. The designated operating room staff member will check each piece of equipment to be used during the day by turning on the apparatus and checking to see that the functions of the unit work properly. With some machinery, it may not be possible for the equipment to run through all of its functions, but the safety of the machinery should be able to be determined by this exercise.
2. A bio-medical person will check each piece of equipment and perform electrical safety checks (preventive maintenance or PM) at least semi-annually and attach labels to the equipment to verify these checks.
3. Documentation of bio-medical/safety checks shall be kept for at least three years.
4. Obvious hazards are reported. Any suspect equipment is immediately pulled from service until cleared. Should there be a suspect piece of equipment, the following procedures shall take place:
 - The Clinical Supervisor or designee shall be notified of the potential equipment malfunction.
 - The Clinical Supervisor shall make the decision to pull the equipment from service. Each staff member has the authority to refrain from using any equipment if they have a valid basis for the belief that the equipment is not functioning properly and/or may cause a hazard for the patient and/or a staff member.
 - The Governing Body-approved bio-medical engineer will be contacted to come out and inspect the equipment. If appropriate, the manufacturer may also be contacted.
 - The suspect equipment shall remain out of service until the bio-medical engineer has inspected, tested and approved the equipment. If the manufacturer inspected the equipment first, the bio-medical engineer must inspect, test and approve the equipment and deem the equipment functioning properly and safe before it is returned to service.
 - The Clinical Supervisor is responsible for ensuring that written documentation is provided by the bio-medical engineer and that the documentation is filed appropriately and retained according to #3 above.

MEDICAL EQUIPMENT MALFUNCTION

POLICY:

In any situation involving a medical device failure or malfunction, immediate steps shall be taken to ensure the health and safety of the patient. Immediate action shall also be taken to preserve the medical device as it was at the time of the occurrence to document the condition/status of the device and to immediately remove the device from service.

PROCEDURE:

At the moment of a medical device failure or malfunction:

1. Attend to the medical needs of the patient or the injured parties, removing them from the area if necessary.
2. The malfunctioning equipment is immediately pulled from service and labeled as NOT IN USE. Do not change any settings or disconnect any attachments.
3. The Clinical Supervisor or Medical Director is to be notified immediately.
4. The bio-med company is to be notified to perform an inspection and diagnosis on the equipment.
5. An incident report is to be filled out. If it is determined that the medical device caused or contributed to a patient or healthcare worker's death or resulted in serious injury or illness, a report will be submitted to the FDA and/or product manufacturer.
(See Incident Report Policy)

MEDICAL EQUIPMENT – USE OF DIRTY EQUIPMENT

POLICY

Equipment that is stored outside the surgical suite (Operating room, Recovery area) shall be considered dirty and shall be cleaned prior to use in the Operating room.

PROCEDURE

1. When it is determined that a piece of equipment stored outside of the surgical suite is to be used in a procedure, the Clinical Supervisor or designee and the Scrub Technician involved in the case shall be notified.
2. The Scrub Technician working in the Operating room on the case utilizing the “dirty” equipment shall ensure that the equipment is wiped down with an anti-bacterial solution prior to the equipment being moved into the Operating room.
3. The Scrub Technician shall also check the equipment to ensure that the equipment has a current preventive maintenance (“PM”) sticker on the equipment. All equipment used in the Operating room and Recovery Room or having patient contact shall be checked by a bio-medical technician at least twice per year (every six months).

MEDICAL EQUIPMENT - SUCTIONING EQUIPMENT

POLICY:

The Nurse Manager is responsible for the correct functioning of the suction system. The Nurse Manager shall familiarize himself/herself with the suction system and be aware of how it performs.

PROCEDURE:

- A. Every case is to be treated as a “dirty” case, using Universal Precautions, including the proper use of protective barrier apparatus.
- B. Following a dirty case, the suction bottles containing aspirate (plus and/or germicide) should be emptied.
- C. A disinfecting agent shall then be used to clean the suction bottle followed by thorough washing with a germicide, rinsing and sterilization.
- D. The disposable suction unit shall be placed in the red bags for infectious waste.
- E. The suction racks and regulator shall be wiped down with a germicidal solution.

STORAGE AND HANDLING OF MEDICAL GASES POLICY

POLICY

All medical gases shall be stored in a designated area and handled in a safe manner as described below.

PROCEDURE:

Delivery

1. Contracted medical gas distributor will deliver medical gases.
2. Upon delivery gases should be placed in designated holders.
3. Cylinders shall be examined upon delivery to determine that tanks are labeled correctly, and to inspect for signs of damage.
4. Return any defective cylinders to distributor immediately if necessary.
5. Delivery schedule should be made in accordance with the needs of the facility.

Storage

1. Cylinders shall be stored upright and secured.
2. All cylinders should be labeled with contents, dangers, and also have a tag to designate whether the tanks are full or empty at all times.
3. When in storage protective steel cap shall remain on the tank.
4. Compressed gas should be in a well ventilated, dry area away from exits and stairways.
5. Group the cylinders by types of gas. Mark empty cylinders and group them together in storage.
6. Oxygen cylinders should be stored at least 20 feet from flammables or combustibles.

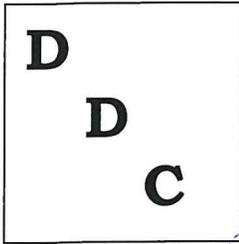
Handling

1. Specifically designed regulators, pressure release valves, hoses and other auxiliary equipment for each gas should be used.
2. Do not drop, bang, slide. Clank, or roll cylinders.
3. Cylinders should be kept in appropriate holder at all times. Holders should be in proper working order.
4. Valves should be closed when not in use.
5. Cylinders should be kept upright.

Usage

1. Leaking containers shall be removed to a well ventilated area. Shut the leaking valve and retighten the valve gland or not.
2. Labels should be legible before cylinders is used, otherwise return cylinder to distributor.
3. Tanks should be kept away from fire, sparks and electricity.

When empty, close and return cylinders to designated area. Empty cylinders shall be tagged as "**EMPTY.**"



**P A T I E N T S A F E T Y
P O L I C Y & P R O C E D U R E**

Policy:

The policy set forth by the Digestive Disease Center (DDC) is to ensure patient safety, before, during, and after a patient's procedure.

Procedure:

- A. Each patient will have a history & physical examination documented in their chart within 7 days prior to their procedure.
- B. Each patient will complete the Medical History Questionnaire prior to his or her procedure.
- C. All patients will receive a copy of the Patient Rights and Responsibilities at the time of scheduling of procedure.
- D. All medical staff is CPR certified, and aware of the location and use of all emergency equipment. All DDC Physicians are ACLS certified.
- E. At least one ACLS certified Registered Nurse is staffed when patients are present in the facility, along with ACLS trained Anesthesiologist is present with sedated patients.
- F. Once a patient has been admitted to the facility, non-sedated patients are visualized frequently to ensure needs are met. Sedated patients are monitored closely checking vital signs with observation to assure patients are free from complications related to the procedure and /or medical problems
- G. Each patient will meet the required discharge criteria set forth by DDC, and ANOR anesthesia standard, prior to being discharged. The physician will have the final decision, to discharge the patient, which will be documented, signed and become part of the patient's record.
- H. A written physician discharge order will be issued to each patient post procedure, providing them with post procedure instructions, precautions, and contact information in case of an emergency. A copy of this document will become part of the patient's record.
- I. The facility staff will make a follow up appointment for the patient as ordered by the physician.
- J. Each patient will be contacted within 24 hours after having their procedure to ensure that they are not experiencing any complications related to the procedure.
- K. A patient safety committee will be formed to include one physician from each site, the nurse manager from each site, the pharmacy consultant, and the medical director. The committee will meet quarterly to discuss patient safety.

2019 policies attached

Policy Title:	SAFETY Management Plan		
Approved:	4/11/2013	Page:	1 of 2
Effective:	4/12/2013	Retired:	

POLICY:

The Center maintains a Safety Management Plan. A culture of safety is central to the identification and correction of issues related to Patient Safety. Digestive Health Center (DHC) promotes this culture by encouraging open discussion regarding safety issues in order to reduce risk to patients, visitors and employees. The plan focuses on system-wide, integrated performance improvement activities, whenever possible to assure an integrated approach to Patient Safety.

PURPOSE:

To provide for the safety of patients, visitors and employees at DHC

PROCEDURE:

Nevada Revised Statute (NRS 439.865) requires all medical facilities to develop, adopt, implement and monitor patient safety activities to improve the health and safety of patients who are treated at DHC. The Operating Board appoints the Center Director to act as the official Safety Officer. The QAPI Committee monitors Safety Management in the following areas:

- General safety– Life Safety Management Plan, Infection Control Policy Online, Inclement Weather and Emergency Situations
- Security – Security Management Plan Policy Online
- Hazardous waste and materials– Hazard Materials and Wastes Management Plan Policy Online
- Emergency preparedness– Disaster Safety Management Plan Policy Online, Inclement Weather and Emergency Situations, Bomb Threat, Bioterrorism Plan
- Fire safety Fire Plan Policy Online
- Environment of care– Facilities and Environment Policy Online
- Medical equipment management– Medical Equipment Management-Operation-Repair Policy Online
- Life safety– Life Safety, Disaster Safety, Fire Plan Policies Online
- Utility systems– Facilities and Environment Policy Online, Physical Plant Utilities Maintenance, Utilities System Management Plan
- Patient safety– Life Safety, Infection Control, Disaster Safety Policies Online, Risk Management Plan, Information Management Plan
- Pharmacy– Pharmacy Policies Online
- Infection Control - Infection Control Policies Online, Exposure Control Plan, Tuberculosis Exposure Control Plan

All employees are in-serviced on the Safety Management Plan at orientation and annually thereafter.

Policy Type:	FE_FACILITIES - ENVIRONMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Last Reviewed: 4/10/2013

Policy Title:	SAFETY Management Plan		
Approved:	4/11/2013	Page:	2 of 2
Effective:	4/12/2013	Retired:	

It is the responsibility of all employees and physician who see a safety management problem or potential problem to immediately notify the Safety Officer. The Safety Officer investigates the report, takes appropriate corrective action and documents findings. The Safety Officer completes an incident report / follow-up report and submits to the QAPI Committee.

Through the Quality Assessment / Performance Improvement Committee and the Safety Officer, the Center implements this plan by:

- Monitoring and supervising all grounds and equipment
- Monitoring of infection control practices on a continuous basis with quarterly reporting to the QAPI
- Conducting risk assessments that proactively evaluate the impact of buildings, grounds, equipment, occupants and internal physical systems on patient and public safety
- Examining safety issues by appropriate representatives from administration, clinical services and support services
- Reporting and investigating all incidents of property damage, occupational illnesses and patient, personnel or visitor injury
- Conducting ongoing hazard surveillance, including response to product safety recalls
- Appointing the Safety Officer/Center Director to intervene whenever conditions pose an immediate threat to life or health, or threaten to damage equipment or building

Implementing an orientation and education plan that addresses:

- General safety processes
- Area specific safety
- Specific job related hazards
- Safety related information through new employee orientation

Conducting ongoing monitoring of performance to asses:

- Staff knowledge and skills
- Monitoring and inspection activities
- Emergency and incident reporting
- Inspection, preventative maintenance, and testing

The objective, scope of performance, and overall effectiveness of the Safety Management Plan is evaluated annually and revised as necessary by the QAPI Committee as documented on the Facilities and Environment Annual Evaluation Form.

Policy Type:	FE_FACILITIES - ENVIRONMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

Policy Title:	RISK MANAGEMENT Plan		
Approved:	9/6/2016	Page:	1 of 5
Retired:			

POLICY:

The Center has a Risk Management Program in accordance with federal, state, local, and accrediting body regulations and guidelines.

PURPOSE:

- A. To provide a safe environment for patients, visitors, volunteers, employees, and medical staff, and to thereby minimize injury and loss
- B. To improve the quality of services provided by identifying the causes of adverse care events and by instituting corrective actions to minimize and/or eliminate the recurrence of untoward events
- C. To minimize claims against the Center
- D. To follow all regulatory laws, standards, and guidelines to report and document adverse events or other incidents involving patients, visitors, volunteers, employees, and medical staff

SCOPE:

The Risk Management Plan applies to all employees and Licensed Independent Practitioners (LIPs) of the Center.

RISK MANAGEMENT COMPONENTS:

The Risk Management Program incorporates the following components:

- A. Risk Identification from:
 - e-Incident reports (The Online Incident Reporting System)
 - Quality Assessment Performance Improvement (QAPI)/e-Incident data analysis
 - High risk/High volume/problem prone procedures
 - Request for records
 - Legal notices or lawsuits
 - ASC Industry Quality measures
 - State, federal, and accreditation surveys
 - Clinical records and reviews
 - Patient grievances/complaints
- B. Risk Control and Analysis through:

Policy Type:	RM_RISK MANAGEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	RISK MANAGEMENT Plan		
Approved:	9/6/2016	Page:	2 of 5
Retired:			

- Root Cause Analysis (RCA)
- Corrective Action Plans, development and implementation
- Trending Risk management/QAPI variances
- Peer review
- Process Improvement
- In-servicing
- Policies and procedures to include:
 - Infection control
 - Credentialing and peer review
 - Compliance Program
 - Confidentiality HIPAA program
 - Employee health
 - Risk Management
 - QAPI

C. Claims Management

Claims management is coordinated by the Corporate Insurance Department in conjunction with the Center Director. The Insurance Department manages and directs all matters regarding:

Claims (actual and potential) Reporting & Management of the following:

- Professional Liability (Malpractice)
- General Liability (Premises Liability), Property Damage
- Workers' Compensation – Claims are reported at the Center, Insurance Department is a resource in regard to benefit and claims questions

Litigation Matters

- All subpoenas/complaints/monetary demands related to the above insurances are forwarded to Insurance for handling in conjunction with the insurance carriers
- All requests for waiver of co-pays or deductibles involving patients or visitors' bills from the Center or other healthcare facilities are submitted as an incident and then referred to the Insurance Department for handling.

RESPONSIBILITY:

It is the ultimate responsibility of the Operating Board to ensure compliance with the Risk Management Program at the Center. The Operating Board has appointed the QAPI Committee to review and analyze Risk Management data and to make recommendations. The Board designates an individual who is responsible for implementation, ongoing management, and consistent application of the Risk Management Program. The Center Director serves as the Risk Manager for the Center.

Policy Type:	RM_RISK MANAGEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	RISK MANAGEMENT Plan		
Approved:	9/6/2016	Page:	3 of 5
Retired:			

The Center Director’s Risk Management duties are to:

- Review, investigate and complete follow-up on all incident reports.
- Coordinate analysis of data for potential trends and outliers.
- Coordinate the analysis of all serious incidents.
- Ensure that incidents are completed and submitted in the online system within 24 hours.
- Present quarterly and annual reports on incidents and Risk Management activities to the QAPI Committee and Operating Board.
- Coordinate the implementation of all action plans developed to reduce risk and improve quality of care.
- Coordinate all staff Risk Management training and in-servicing.
- Provide risk data summaries for credentialing purposes.
- Submit reports as required by the State (if applicable).
- Immediately contact the Corporate Clinical Director for any serious/sentinel event.
- Incorporate Risk Management findings/reports with the QAPI program and initiatives.
- Collaborate with all resources including legal counsel as applicable to coordinate the investigation, processing, and defense of claims against the Center.
- Ensure that the Disclosure Policy is followed regarding serious events.
- Ensure staff participation in incident follow-up including RCA.

Employees’ duties:

In the interest of quality and overall patient safety, employees are responsible to comply with all policies, procedures, and regulations. Each employee has a duty to act on behalf of patients to identify and to report incidents to the Center Director and to participate in the QAPI and Risk Management Programs.

QAPI Committee is responsible to:

- Serve as the oversight committee for the Risk Management Program and is accountable to the Operating Board for implementation.
- Review and evaluate patient care through analysis of the Risk Management reports, to include chart reviews, trends, current issues, and incidents.
- Participate in the identification and resolution of quality or risk issues.
- Utilize risk management and quality data in the credentialing process.
- Review and revise Risk Management policies and reports, including the annual Risk Management Plan, Goals and Evaluation under QAPI.
- Make recommendations to the Operating Board to address quality or risk Issues.

Policy Type:	RM_RISK MANAGEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	RISK MANAGEMENT Plan		
Approved:	9/6/2016	Page:	4 of 5
Retired:			

Operating Board has ultimate responsibility for Risk Management, and also to:

- Provide support and resources for the Risk Management Program.
- Ensure Risk Management is an integral component of the Center’s objectives, plans, and management structure.
- Ensure that appropriate actions are taken based on recommendations from the QAPI Committee and the Center Director.
- Review and approve Risk Management policies and reports, including the annual Risk Management Plan, Goals and Evaluation.

The Operating Board’s commitment to the Risk Management Program, including allocation of human and financial resources necessary to implement and maintain the Program, is evidenced by its approval of the Risk Management Plan on an annual basis.

Insurance and Quality Department:

The Insurance Department and Quality Department are responsible to serve as advisor to the Risk Management and QAPI Programs at the Center. All Risk Management/Quality initiatives are communicated through the Operating Board Chair to the Board for adoption and implementation as appropriate.

EXTERNAL REPORTING: *(if applicable in ASC state)

The Center complies with mandatory reporting to applicable regulatory bodies, including the state of Nevada. The Nevada State of Health Division is responsible for maintaining the Sentinel Events Registry (NRS439.840), which is done by the Office of Public Health Informatics and Epidemiology.

CONFIDENTIALITY:

- The data, reports, and committee minutes generated by Risk Management and Quality Improvement activities are confidential and statutorily privileged. They are accessible only to those individuals who participate in the process and to those agencies responsible for ascertaining the existence of ongoing and effective Risk Management and Quality Improvement Programs.
- QAPI Committee members recognize that any and all data reviewed by them shall be held in strict confidence. Any breach of confidentiality may result in disciplinary action, up to and including termination.
- All requests and/or subpoenas from attorneys and regulatory agencies for information pertaining to patient care, Risk Management and/or Quality Improvement activities must be

Policy Type:	RM_RISK MANAGEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	RISK MANAGEMENT Plan		
Approved:	9/6/2016	Page:	5 of 5
Retired:			

reviewed by the Center Director and forwarded to the Corporate Compliance/Legal Department.

- The e-Incident system is a secure website and is considered confidential.
- All incidents have the following header: "Prepared in anticipation of litigation in consultation with corporate attorneys and as a mechanism for analysis to improve quality and patient safety. Therefore, information within this document is deemed confidential and undiscoverable."

EDUCATION:

Risk Management education will be provided to staff within 30 days of employment and annually thereafter.

Topics for Risk Management education may include, but are not limited to:

- Purpose and goals of Risk Management
- Employee role in Risk Management
- E-Incident reporting system
- Chain of Command
- Root Cause Analysis
- Reporting sexual misconduct, abuse, neglect, or domestic violence
- Safe Medical Device Act (SMDA) reporting
- Advance Directives
- Informed Consent
- Confidentiality & HIPAA
- Patient Rights and Responsibilities
- Patient Grievances
- QAPI
- Infection Control
- Disclosure of medical errors
- Workers' Compensation

(See also HR in-servicing)

ANNUAL REVIEW AND GOALS:

The Operating Board will review and approve the Risk Management policies and reports, including the annual Risk Management Plan, Goals and Evaluation.

Policy Type:	RM_RISK MANAGEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN		
Approved:	2/8/2016	Page:	1 of 8
Retired:			

POLICY

The Center maintains a comprehensive Quality Assessment/Performance Improvement (QAPI) Program to measure, monitor, evaluate and improve clinical outcomes, safety, operational efficiencies, and customer satisfaction in accordance with Federal, State and local regulatory requirements as well as accreditation standards.

PURPOSE/OBJECTIVES

The QAPI Program provides an ongoing, systematic approach to plan, measure, evaluate and improve clinical and operational performance, safety, and service. The fundamental objectives of the program are to:

- Provide high quality, cost effective patient care,
- Plan, design, or revise processes of care and service delivery,
- Maintain a safe environment for personnel, patients and visitors
- Identify opportunities for improvement and utilize an interdisciplinary approach to develop and implement solutions and action plans,
- Establish performance measures which are relevant to the facility scope of service and goals, and which include health outcome and patient safety measures,
- Utilize data in the identification and reduction of medical errors
- Utilize evidence-based practice guidelines and clinical standards, as well as internal and external benchmarking as a basis for improvement efforts,
- Demonstrate measurable, sustained improvements,
- Utilize valid data collection techniques and analysis in QAPI initiatives,
- Involve employees, managers and Medical Staff in QAPI initiatives,
- Integrate the Risk Management, Peer Review, and Infection Control program findings and activities into the QAPI Program
- Achieve high-level customer satisfaction,
- Coordinate QAPI activities to minimize duplication of effort, communicate findings and improvements, and be carried out in a cost effective manner.
- Communicate the QAPI Program findings and results of improvement efforts

MISSION

The QAPI program supports the center purpose/mission statement.

Policy Type:	QAPI_QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN		
Approved:	2/8/2016	Page:	2 of 8
Retired:			

Digestive Health Associates/Digestive Health Center provides diagnosis, treatment and education to patients who are referred to the practice from physicians of Northern Nevada and Eastern California. Our essential priority is to provide exceptional quality, cost-effective care in a healing environment. We show respect and empathy in all interactions with patients, families, physicians and each other.

SCOPE OF CARE

The QAPI Program involves all aspects of care delivery. The facility is an Ambulatory Surgery Center which provides clinical and support staff, as well as the facilities and equipment, to support delivery of appropriate, safe and effective care to an outpatient population ranging from age 16 to geriatric age groups.

Services include: GI Endoscopy

Anesthesia services include: Conscious sedation, monitored anesthesia care/propofol sedation.

RESPONSIBILITY FOR QAPI PROGRAM

Governing Board – The Northern NV Endoscopy ASC, LLC

The Governing Board has the ultimate authority and accountability for the QAPI Program. The Governing Board delegates to the Medical Staff and center management the responsibility for implementation of the QAPI program. The Governing Board is responsible to:

- Assure that the QAPI program is defined, implemented, and maintained as an integral component of the Center’s objectives, plans and management structure,
- Provide resources to support the QAPI program,
- Assure that the QAPI program addresses the priorities of the center
- Assure that improvements are evaluated for effectiveness
- Assure that the QAPI program specifies data collection description, methods, and frequency
- Oversee the coordination of Risk Management, Quality Assurance/Performance Improvement, Infection Control and Peer Review
- Assure that services provided by contracted services are provided in a safe and effective manner
- Promote a safety culture
- Review and approve QAPI policies, the QAPI program goals, and annual program evaluation.

Center Director and Management Team

The center management team, supported by the corporate Clinical Director, has overall responsibility for the implementation and maintenance of the QAPI program to:

- Ensure patient care is delivered safely,

Policy Type:	QAPI_QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN		
Approved:	2/8/2016	Page:	3 of 8
Retired:			

- Ensure the ongoing competence of staff,
- Support an environment that promotes process improvement, quality outcomes, patient safety and customer satisfaction,
- Monitor important aspects of care to identify and address opportunities for improvement,
- Take appropriate actions to address identified quality issues and monitor their effectiveness
- Provide education to employees regarding improvement strategies,
- Foster a blame-free environment in addressing incidents,
- Sustain improvements made to departmental functions,
- Support staff participation in internal and external educational programs,
- Use industry standards, evidence-based practices and benchmarking when available to evaluate performance opportunities,
- Utilize QI findings in policy and procedure development, departmental education and the evaluation of individual performance, and
- Ensure continuous compliance with accreditation standards and Regulatory requirements.

Quality Assessment Performance Improvement (QAPI) Committee

The QAPI Committee is responsible to assure that the QAPI plan is implemented and maintained. The Committee consists of the Center Director, Medical Director or designated medical staff representative, Admitting/Business/Reception, Pharmacy Consultant, Anesthesia representative and other such members that may be approved by the QAPI Chairman. The QAPI Chairperson is a physician who is an active member of the center's medical staff and is not the same person as the Medical Director. (AAAHC requires one or more physician leaders be involved in the quality activities of the center)

The QAPI Committee meets on a quarterly basis. The Center Director is responsible for facilitation of the meetings and maintenance of the minutes. *

Specific functions of the Committee include:

- Ensure the QI plan is implemented, maintained and reviewed annually
- Objectively and systematically review the quality of service delivery and related performance measures
- Develop and revise indicators as necessary to evaluate care
- Review data summaries for all identified indicators, as well as other sources of information regarding quality of care, patient safety, and health outcomes
- Review of internal and external benchmarking data to identify opportunities for improvement
 - Oversee all patient safety and risk management activities,
 - Identify opportunities for improvement and assure that appropriate action is taken
 - Develop educational programs based on needs identified through QAPI activities.

Policy Type:	QAPI_QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN		
Approved:	2/8/2016	Page:	4 of 8
Retired:			

- Support education regarding the principles of continuous improvement and the center's QAPI program
- Ensure integration of Risk Management and Infection Control activities into the QAPI plan

Quality Improvement Teams

QI Teams may be appointed by the QAPI Committee to address departmental, inter-departmental, multidisciplinary and/or interdisciplinary issues.

QI Teams may be initiated based on the following priorities:

- Support of the Strategic Business Plan
- Customer needs and expectations, patient satisfaction survey results, physician satisfaction survey results
- Important aspects of care
- High volume / high risk occurrences
- Problem prone issues
- Financial opportunities
- Regulatory or compliance requirements
- Patient safety

QI Teams provide progress reports to the QAPI Committee on a quarterly basis.

Employees

Employees are responsible to provide quality care and services to all customers and to comply with Center policies and procedures. Employees actively participate in the facility's QAPI program and promote communication regarding Quality, Risk, Safety, and Infection Control issues. (See Policy: Quality Measures – Performance Improvement Indicators)

QUALITY MEASURES/PERFORMANCE INDICATORS

Data is collected on an ongoing basis and utilized to prioritize performance activities and focus on high risk, high volume, and problem prone areas.

Categories of indicators include, but are not limited to, the following:

- Case Volume/Procedure Statistics
- Postoperative Infections
- Employee Health

Policy Type:	QAPI_QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN		
Approved:	2/8/2016	Page:	5 of 8
Retired:			

- Post-op Contacts
- Risk Management/Safety
- Adverse Patient Events
- Patient Satisfaction/Grievances
- Medical Records Process/Documentation Review
- Prep quality
- Cecal Intubation Rate
- Day of Procedure Cancellations
- Competency
- Pathology/Adenoma detection
- Facility Utilization
- Pharmacy/Medication
- Credentialing (# credentialed/re-credentialed only)
- Compliance/Privacy

Endoscopy centers collect assigned data in the following categories as appropriate, as GIQuIC measures are included:

- Adenoma detection rate
- Adequacy of bowel prep
- Adverse events
- Adverse events-incidence of perforation
- Age appropriate screening colonoscopy
- Appropriate follow-up interval for normal colonoscopy in average risk patients
- Appropriate indication for colonoscopy
- ASA category documentation
- Average withdrawal time (min)
- Colonoscopy indication documentation
- Colonoscopy interval for patients with a history of adenomatous polyps-avoidance of inappropriate use
- Photo documentation of the cecum-all colonoscopies
- Photo documentation of the cecum-screening colonoscopies
- Repeat colonoscopy recommended due to poor bowel preparation
- Written discharge instructions rate
- History and physical documentation
- Informed consent documentation
- Incidence of post-polypectomy bleeding

All centers collect data on the following Surgical Care Improvement Project (SCIP) measures as applicable:

Policy Type:	QAPI_QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN		
Approved:	2/8/2016	Page:	6 of 8
Retired:			

- IV Antibiotic Timing
- Wrong site, side, patient, procedure, or implant
- Patient burn
- Patient fall in the ASC
- All-cause hospital transfer or admission

BENCHMARKING

Benchmarking is integrated into the QAPI program in order to identify best practices and comparative information utilized for improvement. Internal benchmarking compares performance within the facility such as physician or department, or over time. External benchmarking is conducted with other AmSurg facilities through data sharing and dissemination of best practices. Examples of external benchmarking include the Corporate Quality Studies, monthly stat reports, and comparisons with external sources as the ASC Quality Collaboration. Other sources are utilized as applicable to the particular focus area and may include specialty-specific references and standards.

QUALITY STUDIES (FOCUS STUDIES)

The Center conducts at least two QAPI focus studies on an annual basis. At least one study must demonstrate that improvement has occurred. At least two focus studies are conducted each year

Sources of information that can initiate a focus study may include:

- Evaluating trends identified from results of ongoing data monitoring—see QAPI Outline
- Review Center process.
- Evaluation of performance in comparison to industry indicators/benchmarks (i.e., colonoscopy withdrawal time; antibiotic timing; unplanned vitrectomy rates; post-operative infections)

The 10-Step QAPI Focus Study Worksheet is utilized to document each study.*

Quality studies reflect the scope of services, center priorities, and findings from performance monitoring. Studies address clinical, administrative, and/or cost of care issues and are documented in a consistent format which includes:

- Identification of the process improvement opportunity/purpose of the study
- Identification of the performance goal
- Description of the data that will be collected
- Evidence of data collection

Policy Type:	QAPI_QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN		
Approved:	2/8/2016	Page:	7 of 8
Retired:			

- Data analysis that describes findings
- Comparison of the current performance compared to goal
- Implementation of corrective action(s) to resolve identified problem(s)
- Re-measurement to determine whether the corrective actions have achieved and sustained demonstrable improvement
- Implementation of additional corrective action(s) and re-measurement if initial corrective action(s) did not achieve and/or sustain the desired improved performance
- Communication of the findings to the Governing Board and throughout the organization

INTEGRATION WITH RISK MANAGEMENT

Risk Management is linked operationally with QAPI to maximize patient, staff, and visitor safety. Improving the quality of care reduces risk exposure.

The operational linkage between Risk Management, Safety, Quality Improvement, and Infection Control is accomplished through the following mechanisms:

- Issues or trends identified in chart reviews, specialty reviews, infection control reports, and environmental rounds will be referred to the Center Director or designee for evaluation and/or corrective action.
- Data from incidents, identified trends, adverse events or any events that impact the quality or safety of patient care will be referred to the Center Director or designee for investigation, analysis and corrective action. Adverse events analysis are summarized and reported to the QAPI Committee on a quarterly basis.
- The Risk Manager (if applicable) and Center Director review current issues and risk reduction strategies; these are discussed at staff meetings as needed.
- The QAPI Committee serves as the oversight committee for Risk Management and Safety. Risk Management and Safety reports are presented to the QAPI Committee on a quarterly basis. (See Risk Management Toolkit)

REPORTING

QAPI Committee reports are provided to the Governing Board on a quarterly basis.

Policy Type:	QAPI_QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN		
Approved:	2/8/2016	Page:	8 of 8
Retired:			

CONFIDENTIALITY

All QAPI activities and data are considered confidential. Any requests from outside sources for any QI, Risk Management, Peer Review, Infection Control or credentialing information or reports are forwarded to AmSurg Risk Management. All provider and patient identification is protected in all minutes and reports. Reports and minutes are secured and maintained by the Center Director.

PROGRAM EVALUATION

The QAPI program is evaluated annually to determine its effectiveness and to assure that patient care and/or safety issues were identified and addressed. All recommendations from accreditation surveys, auditors, regulatory agencies and evidence-based sources are considered when evaluating the need for program revision. The Governing Board approves the annual program evaluation. *****

ANNUAL GOALS

The QAPI Committee establishes goals for the QAPI program on an annual basis. Factors identified in the annual program evaluation are considered in the establishment of subsequent goals. The Governing Board approves the annual goals.

PROGRAM APPROVAL

The Governing Board approves the QAPI program on an annual basis. (See QAPI Toolkit)

Policy Type:	QAPI_QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	LIFE SAFETY Management Plan		
Approved:	11/4/2012	Page:	1 of 2
Effective:	1/13/2013	Retired:	

POLICY:

The Center maintains a Life Safety Management Plan.

PURPOSE:

To provide safety from fire hazards

PROCEDURE:

The Center has processes for:

- Protection of patients, personnel, visitors and property from fire, smoke and other products of combustion
- Maintenance of building structural requirements for fire protection
- Inspection, testing and maintenance of fire alarm systems, through annual preventative maintenance inspections.
- Inspection, testing of fire alarm / fire detection systems
- Minimize smoke transmission by controlling designated fans and dampers in air-handling and smoke management systems
- Transmits the alarm to the local fire department
- Inspection and maintenance of all fire extinguishers
- Review of proposed acquisitions of fabrics, wall coverings and upholstery, and other decorations
- Reporting of all incidents or Life Safety Code (LSC) and fire protection deficiencies, failures or user errors. Review of all incident reports by the Center Director, who forwards the report to the appropriate committees for discussion and resolution. In addition the Center Director provides a life safety orientation and education plan that addresses:
 - Roles and responsibilities of personnel at fire's point of origin
 - Roles and responsibilities of other staff as needed during a fire or building evacuation
 - Use and function of fire alarm systems
 - Use of equipment for evacuating or transporting patients to areas of refuge
 - Building compartmentalization procedure for containing smoke and fire

Education is provided at new employee orientation and annually. Training in-services may also be conducted at monthly in-services or staff meetings.

Policy Type:	FE_FACILITIES - ENVIRONMENT
Center:	Reno GI
Center DBA:	Digestive Health Center

Policy Title:	LIFE SAFETY Management Plan		
Approved:	11/4/2012	Page:	2 of 2
Effective:	1/13/2013	Retired:	

The Life Safety Management Plan has procedures to address:

- Fire response and fire evacuations routes
- Role of personnel at point of origin of fire
- Responsibilities of other staff as needed during a fire or building evacuation

The Life Safety Management Plan is evaluated annually by the QAPI Committee as documented on the Facilities and Environment Annual Evaluation Form.

Policy Type:	FE_FACILITIES - ENVIRONMENT		
Center:	Reno GI		
Center DBA:	Digestive Health Center		

May not be valid after 1/22/2018

Last Reviewed: 11/3/2012

Policy Title:	INFECTION CONTROL PROGRAM		
Approved:	9/6/2016	Page:	1 of 7
Retired:			

POLICY:

The Center maintains an ongoing Infection Control program that is a result of a formal, documented infection prevention risk assessment, to ensure that the program is relevant to the Center.

PURPOSE:

To prevent, control, and investigate infections and communicable diseases among patients, healthcare workers, and visitors

SCOPE OF THE INFECTION CONTROL PROGRAM:

The Infection Control Program is comprehensive in that it addresses detection, prevention and control of infections among patients and personnel.

COMPONENTS OF THE INFECTION CONTROL PROGRAM:

RESPONSIBILITY:

The Governing Board is the ultimate authority for the Infection Control program. Ongoing responsibility for the program is assigned by the Governing Board to an individual who receives special training regarding Infection Control and the responsibilities of the position. The designated individual is a member of the QAPI Committee and provides quarterly reports regarding the program activities, findings and improvement strategies. The QAPI Committee functions as the Infection Control Committee.

The Center adheres to professionally accepted standards of practice, manufacturer's recommendations, and state and federal guidelines, including but not limited to the cleaning, disinfection and sterilization of instruments, endoscopes, equipment, supplies and implants.

The Governing Board has approved the adherence to nationally recognized infection control guidelines as outlined by CDC, APIC, OSHA, and SGNA.

Professional guidelines to be utilized in the implementation of the Infection Control Program:

Evidence based policies and procedures based upon CDC, APIC and OSHA guidelines.

Policy Type:	IC_INFECTION CONTROL
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	INFECTION CONTROL PROGRAM		
Approved:	9/6/2016	Page:	2 of 7
Retired:			

INFECTION CONTROL COORDINATOR

Responsibility is delegated to the Infection Control Coordinator (ICC) to carry out the daily functions of the Infection Prevention Program. Those functions are described in the ICC job description. The ICC has knowledge and interest in Infection Prevention and has received initial and ongoing training in the principles and methods of infection control. The Infection Control Coordinator is provided adequate time to direct the Infection Control Program. The Infection Control Coordinator serves as a resource for all staff relating to prevention of infections.

SURVEILLANCE:

Surveillance is an active process to identify and analyze outcomes related to infection control, and includes:

- Environmental surveillance to identify and correct practices found in the workplace, i.e., hand hygiene, safe injection practices, use of PPE
- Preventive surveillance such as immunization of staff
- Observation and documentation of sterilization and disinfection practices
- Verification of education and training for staff
- Conformity with safe sharps handling
- Public Health reporting and monitoring of community trends
- Post-procedure surveillance conducted through reports sent to physicians
(See Infection Control Surveillance)

OUTBREAK INVESTIGATION

Systems are in place to facilitate recognition of increases in infections as well as clusters and outbreaks.

PATIENT ASSESSMENT AND TRIAGE

All patients receive a pre-procedure assessment of current and past health history, including a symptom-based evaluation for current communicable disease as evidenced by the nursing

Policy Type:	IC_INFECTION CONTROL
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	INFECTION CONTROL PROGRAM		
Approved:	9/6/2016	Page:	3 of 7
Retired:			

assessment. The ambulatory care setting does not provide for isolation rooms and therefore contact with patients who are potentially contagious must be limited. (See ASSESSMENT Pre Procedure)

HAND HYGIENE

Protocols for proper hand hygiene and surgical hand antisepsis are an essential element of the program (See HAND HYGIENE)

LAUNDRY SERVICES

Center policies and procedures outline the handling, processing, and storage of clean and dirty linen, as well as the use of disposable supplies. (See LAUNDRY Contaminated and SINGLE USE MEDICAL DEVICE)

ENVIRONMENT of CARE

Environmental factors reviewed as part of the Infection Control plan include:

- Workflow to prevent cross contamination
- Sterilization and reprocessing procedures and documentation
- Ventilation
- Temperature and humidity of rooms
- Appropriate ventilation and maintenance of systems
- Housekeeping responsibilities
- Disinfection of surfaces between patients
- Cleaning schedules, and pest management

EDUCATION

Orientation and training regarding infection prevention and control is conducted by the designated Infection Control Professional and includes the topics:

- hand hygiene
- high level disinfection/sterilization
- waste management procedures
- infection prevention principles and practices

Policy Type:	IC_INFECTION CONTROL
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	INFECTION CONTROL PROGRAM		
Approved:	9/6/2016	Page:	4 of 7
Retired:			

Information related to employee health is also included.

Documented education in Infection Control Policies and processes is provided to all staff within 10 days of commencement of employment, annually thereafter, and when there is an identified need.

Credentialed providers receive ongoing or, at a minimum, annual infection control training.

QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT STRATEGIES (QAPI)

Monitoring of infection control measures is conducted and variances are reported for specific occurrences. Corrective and preventive measures for improvement are undertaken immediately as needed. Infection Control is a component of the facility's Quality Assurance Performance Improvement Program (QAPI) and infection control reports are made to the QAPI committee. In addition, infection control audits are performed to assess the level of quality provided and actions for improvement are taken as needed.

The QAPI Committee meets on a regular basis and provides input and direction for the Infection Prevention Program. Policies and procedures relating to Infection Prevention are approved by the committee. Reports of infections are presented to the committee which recommends actions and control measures when needed.

REPORTING MECHANISMS FOR INFECTION CONTROL

Patient infection cases are monitored by the ICC. The ICC completes a list of infections, the monthly report forms and:

- Reports to the QAPI Committee
- Reports to the Governing Board
- Reports to health authorities, if appropriate
- Provides feedback to staff as needed.

Employee infections are reported by the employee to the Supervisor and Center Leader, then to the ICC. The ICC completes the employee infection report form and reports:

- Compliance with infection control practices is monitored and documented by:
 - Staff evaluation
 - Observation of Practices
 - The ICC and Center Leader review the compliance monitoring and initiate appropriate actions.

Policy Type:	IC_INFECTION CONTROL
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	INFECTION CONTROL PROGRAM		
Approved:	9/6/2016	Page:	5 of 7
Retired:			

UPDATING THE INFECTION CONTROL PLAN:

The Infection Control Plan is reviewed annually by the Infection Control Committee/QAPI Committee. Revisions, if needed, will be made to the plan based on review.

POLICIES AND PROCEDURES

Policies and procedures for infection prevention are reviewed on a regular schedule and updated as needed.

The following Infection Control policies and procedures are maintained and made part of the Center Infection Control Plan:

- Airborne Precautions
- Annual Evaluation of Infection Control Program
- Asepsis Principles of
- Cleaning New-Repaired or Loaner Equipment
- Cleaning Procedure Room
- Communicable-Infectious Diseases Personnel
- Communicable-Infectious Diseases Patients
- Consent Form to Draw Blood
- Contact Precautions
- Disinfection High-Level
- Disinfection of Non-Critical Devices
- Droplet Precautions
- Exposure Control Plan
- Hand Hygiene
- Hepatitis B Immunization Documentation for employees
- Hepatitis B Vaccine General Information

Policy Type:	IC_INFECTION CONTROL
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	INFECTION CONTROL PROGRAM		
Approved:	9/6/2016	Page:	6 of 7
Retired:			

- Hepatitis B Vaccine Immunization Program for employees
- Infection Control Agents Center Approved*
- Infection Control Annual Risk Assessment
- Infection Control Committee
- Infection Control Meeting Minutes Template-QAPI
- Infection Control Multi-Drug Resistant Organisms (MDRO)
- Infection Control Orientation Checklist
- Infection Control Orientation Outline
- Infection Control Program
- Infection Control Standard Precautions and Practices
- Infection Control Surveillance Plan
- Infection Control Training-Orientation
- Influenza Vaccine Availability for Employees
- Influenza Vaccine Consent
- Outbreak Investigation
- Reprocessing Endoscope
- Reprocessing Instruments
- Sharps Injury Log
- Sharps Injury Protection Plan
- Skin Preparation
- Sterile Supplies Opening
- Sterilization Monitoring Process

Policy Type:	IC_INFECTION CONTROL
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

Policy Title:	INFECTION CONTROL PROGRAM		
Approved:	9/6/2016	Page:	7 of 7
Retired:			

- Sterilization Packaging
- Sterilization-Disinfection Products Center Approved*
- Storage Sterile
- Traffic Control
- Tuberculin Skin Tests Competency
- Tuberculosis Screening for Employees

REFERENCES:

Association for Professionals in Infection Control and Epidemiology, Inc. (APIC)

2005 APIC Text of Infection Control and Epidemiology/Ambulatory Care

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Internet www.apic.org

Society of Gastrointestinal Nurses and Associates

www.sgna.org

Centers for Disease Control and Prevention (CDC)

www.cdc.gov

Occupational Safety and Health Administration

<http://www.osha.gov>

Accreditation Association for Ambulatory Health Care, Inc.

2016 Accreditation Handbook for Ambulatory Health Care

STANDARD 7.I.b

www.aaahc.org

Centers for Medicare and Medicaid Services

<http://www.cms.hhs.gov>

Policy Type:	IC_INFECTION CONTROL
Center:	Reno GI
Center DBA:	Digestive Health Center

May not be valid after 1/22/2018

January 1, 2015
Reviewed

1-1-16

1-1-17

1-1-18

1-1-19

Ford Center for Foot Surgery

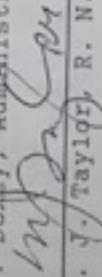
Policy: Safety Plan

Purpose: To provide a safe environment for all patients, employees, and physicians.

- Procedure:
1. All electrical equipment is in optimal condition.
 2. No frayed cords or loose plugs.
 3. Emergency power has been checked.
 4. Air conditioner filters will be serviced quarterly.
 5. Temperature and humidity checked to be at a comfortable level for the patients and staff.
 6. Bio-Med person will check equipment and electrical safety annually.
 7. O.R. rooms and electrical equipment checked on surgical days.
 8. Emergency call systems are located in O.R., Changing rooms, Pre-Op room, and Post-op Room. They are checked to be in working condition on operative days.
 9. Wheelchair is in working condition.
 10. Crutches are in working condition.
 11. All walkways are clear of debris, and cleared of ice snow, and water.

Signatures:


D. Doney, Administrator


M. J. Taylor, R. N.

**NEVADA ENDOSCOPY MANAGEMENT, INC
GASTROENTEROLOGY CONSULTANTS, LTD
RENO ENDOSCOPY CENTER, LLC
SOUTH MEADOWS ENDOSCOPY CENTER, LLC
CARSON ENDOSCOPY CENTER, LLC**

POLICY AND PROCEDURE MANUAL

Policy: Patient Safety Plan
Owner: Center
Date last updated: Revised 4/2016

Purpose: Gastroenterology Consultants, Ltd (GIC) and affiliated Endoscopy Centers are committed to ensuring the ongoing safety of our patients. To ensure the ongoing safety and care of our patients we follow specific guidelines and policies which, at a minimum, include:

I. Infection Control (IC): Refer also to the Infection Control (IC) Policy

1. Guidelines followed include:

- a. American Society for Gastrointestinal Endoscopy (ASGE) Multisociety Guideline on Reprocessing Flexible Gastrointestinal Endoscopes 2011
- b. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes 2015
- c. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standard of Infection Prevention in the Gastroenterology Setting 2015
- d. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Guideline for Use of High Level Disinfectants and Sterilants for Reprocessing Flexible Gastrointestinal Endoscopes 2013
- e. American Society for Gastrointestinal Endoscopy (ASGE) Infection Control during GI Endoscopy 2008
- f. Center for Disease Control (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007
- g. CDC Guide to Infection Prevention for Outpatient Settings 2014
- h. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the Elimination of Clostridium difficile in Healthcare Settings 2013
- i. CDC Safe Injection Practices

2. The IC Policy includes, at a minimum, processes or guidelines for:

- a. Patient selection and placement within the facility
- b. Infection Control Monitoring and Surveillance, Reporting
- c. Standard and Transmission Precautions, Hand Hygiene, Personal Protective Equipment, Respiratory Hygiene / Cough Etiquette and General Infection Control Practices in Healthcare Facilities as developed by the CDC and APIC
- d. Environmental and Terminal Cleaning
- e. Infection Control Officer

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

- f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

II. Patient Selection and Screening: Refer also to the Criteria for Scheduling Patients at ASC Policy.

1. To ensure patients are appropriate for the planned procedure in the planned setting patients undergo:
 - a. Pre-procedure scheduling evaluation with referral for office visit or consultation as appropriate
 - b. Pre-procedure assessment which includes at a minimum:
 - i. Review of past medical & surgical history
 - ii. Medication reconciliation, review
 - iii. Allergy and reaction, review of
 - iv. Physical assessment; assessment for communicable diseases
 - v. Vital signs

III. Patient Identification: Refer to Patient Identification Policy. Patient identity is verified with at minimum two (2) identifiers at check-in and at multiple points throughout care.

IV. Safe Surgery Checklist: Refer to Safe Surgery Checklist Policy. Patient and procedure are verified immediately prior to procedures.

V. Discharge Teaching: Patients are provided with written discharge instructions which are reviewed with patient and driver, as applicable, prior to discharge. Medications are reconciled prior to discharge if any new medications are ordered. Information specific to diagnosis, as best as known, is given to the patient. Patients are educated about signs and symptoms to report and given a twenty-four (24) hour telephone number to call in event of questions or concerns.

VI. Post Procedure Callbacks: Patients are contacted one (1) to two (2) business days post-procedure for follow up of any concerns and questions regarding discharge instructions.

VII. Pathology follow up: Patients are notified of pathology results and given information and follow up orders as applicable within two (2) weeks.

VIII. Pharmaceutical Services: Refer to Pharmaceutical Services Policy. Safe injection practices are strictly followed. Pharmaceutical services are overseen by a contracting pharmacist on a monthly basis.

IX. Quality Assurance and Benchmarking: Refer to the Quality Management Plan. More than one hundred (100) quality assurance checkpoints are monitored on per patient, per case, per day, per week or per month basis as applicable. Benchmarking of multiple facility and nursing care factors are completed on an ongoing basis. In addition, multiple procedure-related factors are tracked and trended in aggregate and specific to individual

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physicians on an ongoing basis. Incidents, procedure complications/events, adverse and sentinel events are investigated tracked and trended by facility, staff and physician. All data is reported to the Quality Management Committee.

- X. Staff Training:** Extensive staff training is done at time of hire. Annual staff retraining is mandatory; ongoing training is provided as applicable. Staff are evaluated for customer service and performance on an ongoing basis.
- XI. Checklists:** All items above are monitored via specific checklists, logs and or chart documentation.

Refer to:

- Infection Control Policy
- Criteria for Scheduling Patients at ASC Policy
- Identification of Patient Policy
- Pharmaceutical Services Policy
- Quality Management Plan
- Safe Surgery Checklist Policy
- Incident Reports Policy
- Complications: Procedure Event, Adverse and Sentinel Events Policy
- Staff Training Competencies and Logs
- NRS 439.865; 439.877

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

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Policy Title:	SAFETY Management Plan		
Approved:	2/19/2013	Page:	1 of 2
Effective:	2/28/2013	Retired:	

POLICY:

The Center maintains a Safety Management Plan.

PURPOSE:

To provide for the safety of patients, visitors and employees

PROCEDURE:

The Operating Board appoints the Center Director to act as the official Safety Officer. The QAPI Committee monitors Safety Management in the following areas:

- General safety
- Security
- Hazardous waste and materials
- Emergency preparedness
- Fire safety
- Environment of care
- Medical equipment management
- Life safety
- Utility systems
- Patient safety
- Pharmacy

All employees are in-serviced on the Safety Management Plan at orientation and annually thereafter.

It is the responsibility of all employees and physician who see a safety management problem or potential problem to immediately notify the Safety Officer. The Safety Officer investigates the report, takes appropriate corrective action and documents findings. The Safety Officer completes an incident report / follow-up report and submits to the QAPI Committee.

Through the Quality Assessment / Performance Improvement Committee and the Safety Officer, the Center implements this plan by:

- Monitoring and supervising all grounds and equipment

Policy Type:	FE_FACILITIES - ENVIRONMENT
Center:	Las Vegas East Eye
Center DBA:	Shepherd Eye Surgicenter

Policy Title:	SAFETY Management Plan		
Approved:	2/19/2013	Page:	2 of 2
Effective:	2/28/2013	Retired:	

- Conducting risk assessments that proactively evaluate the impact of buildings, grounds, equipment, occupants and internal physical systems on patient and public safety
- Examining safety issues by appropriate representatives from administration, clinical services and support services
- Reporting and investigating all incidents of property damage, occupational illnesses and patient, personnel or visitor injury
- Conducting ongoing hazard surveillance, including response to product safety recalls
- Appointing the Safety Officer/Center Director to intervene whenever conditions pose an immediate threat to life or health, or threaten to damage equipment or building

Implementing an orientation and education plan that addresses:

- General safety processes
- Area specific safety
- Specific job related hazards
- Safety related information through new employee orientation

Conducting ongoing monitoring of performance to asses:

- Staff knowledge and skills
- Monitoring and inspection activities
- Emergency and incident reporting
- Inspection, preventative maintenance, and testing

The objective, scope of performance, and overall effectiveness of the Safety Management Plan is evaluated annually and revised as necessary by the QAPI Committee as documented on the Facilities and Environment Annual Evaluation Form.

Policy Type:	FE_FACILITIES - ENVIRONMENT
Center:	Las Vegas East Eye
Center DBA:	Shepherd Eye Surgicenter

**Sierra Center for Foot Surgery's
Patient Safety Plan
Patient Safety Committee**

The goal of the Sierra Center for Foot Surgery's internal patient safety plan is to improve the health and safety of patients who are treated at the medical facility. It is developed in consultation with the actual providers of health care to the facility's patients. The center's safety plan is delineated in the center's policy and procedure manual and includes policies and procedures related to:

Surgical Time Out
Surgical Site Marking
Emergency Call System
Safe Use of Electrical Equipment
Facility Safety Checklist
Facility Maintenance and Safety
Equipment Safety Log
Emergency Drills:

- Fire Drills
- Earthquake Drills
- Bomb Threats
- Medical Emergency Drills

Patient Positioning

The center's Program for The Prevention and Control of Infections and Communicable Diseases, includes policies and procedures related to:

Medication Safety

- Single Dose vials
- Multi-dose vials
- Anesthesia Services

Syringe and Needle Use
IV Infusions
Disinfection
Sterilization
Aseptic Technique
Communicable Diseases and Resistant Infections
Hand Hygiene
Gloves

The center's infection control and patient safety policies and procedures are reviewed and approved at least annually. Infection control, patient safety and communicable disease policies and procedures are also reviewed and reinforced via annual face to face in-services. If new and improved infection control practices, patient safety practices or new information on communicable disease control and/or prevention are discovered before that time they are discussed and reviewed with the Director of Nursing, medical director and any pertinent staff members, in-serviced and put into effect at that time.

The Sierra Center for Foot Surgery has designated Jessica Bell, RN to serve as the center's Patient Safety Officer. She has the responsibility to serve on the patient safety committee, supervise the reporting of all sentinel events, take action as deemed necessary to ensure patient safety at the facility and report any action taken to the patient safety committee.

Patient Safety Committee:

The center's patient safety committee is comprised of all the staff members of the center, including the Director of Nursing and the Medical Director who is considered the "CEO" of the center.

The committee shall meet once annually.

The patient safety committee shall:

Receive reports from the patient safety officer pursuant to NRS 439.870

Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.

Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.

**Southwest Medical,
Part of Optum Care**

PATIENT SAFETY PLAN

MARCH 1 2019



Southwest Medical™
Part of OptumCare™

The Southwest Medical Patient Safety committee/team created the plan and revises/updates it annually. Implementation of this plan is intended to optimize healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, and reduce the medical/healthcare errors and /or preventable events

Patient Safety Committee/Program
Southwest Medical, Part of Optum Care
Las Vegas, Nevada

Contents

Commitment to Patient Safety.....	3
Mission, Vision, Values.....	3
Scope and Purpose.....	3
Roles and Responsibilities.....	4
Objectives.....	11
Components and Methods.....	11
Root Cause Analysis.....	12
Performance Improvement Model.....	12
Data Collection.....	13
Reporting.....	13
Plan Assessment.....	14
Patient Safety Checklists and Polices.....	14
Plan Approval.....	15
References.....	16
Terms and Definitions.....	17

Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision and values, Southwest Medical's Patient Safety and Quality Improvement program promotes:

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

Plan Scope and Purpose

The scope of the Patient Safety Committee organizational-wide and includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

The Committee provides oversight for patient safety activities, infection control activities, initiatives to promote patient safety and monitoring and review of medical/healthcare errors/potential errors involving patients, visitors, SMA staff, students and volunteers

All staff members at Southwest Medical are expected to fully support and participate in this plan and devote their expertise, knowledge, vision, skill, and insight to the patient safety and healthcare quality improvement process

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering a culture of safety through personal example by:

- Emphasizing patient safety as an organizational priority
- Providing education to medical and facility staff regarding the commitment to reduction of medical errors
- Supporting proactive reduction in medical/health care errors
- Integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services

The purpose of the Patient Safety Plan is:

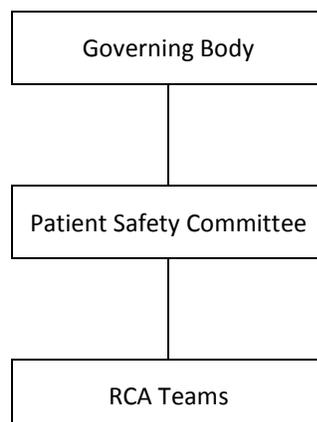
- To address patient safety related concerns and challenges
- To reduce risk
- To respect the dignity of those Southwest Medical serves by assuring a safe environment
- To periodically evaluate and revise the program to better serve patients and their families

Roles and Responsibilities

Southwest Medical created an organization-wide Patient Safety Plan that includes the medical facilities (Surgery Centers) as directed by [NRS 439.875](#) a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully

The Southwest Medical Patient Safety Committee

- Is a standing confidential interdisciplinary committee formed to manage the Southwest Medical’s Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach
- Will meet monthly to assure maintenance and improvement of patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Will report and discuss events including:
 - Number of sentinel events from previous calendar quarter
 - Number of severe infections from previous calendar quarter
 - Corrective action plans
 - Corrective action plan evaluation
 - Patient safety policies and checklists
- Will monitor and document the effectiveness of the patient safety policy
- Will evaluate patient safety policies and checklists at least annually
- Will revise patient safety policies and checklists as needed
- Will convene a RCA meeting/team as necessary
- Review the RCA process and quality improvement related activities and timelines
- Identify barriers and technical assistance needs for supporting the RCA efforts
- Discuss corrective action process and activities



Patient Safety Committee Membership

In accordance with [NRS 439.875](#), the Patient Safety Committee will include:

- The Patient Safety Officer
- The Infection Prevention and Employee Health Medical Director

- At least three providers of healthcare who treat patients , including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff
 - Medical Director Specialties
 - Medical Director Primary Care
 - Medical Director On Demand Medicine
 - Medical Director Clinical Education Programs
 - Medical Director Surgery Centers
 - Associate Vice President Surgery Centers (RN and Administrator)
 - Chief Nursing Officer
 - RN Executive Director On-Demand Medicine
 - RN Director Specialties
 - Director Imaging Services
 - Pharmacy Consultant (PharmD)
 - RN Managers Surgery Centers
 - RN Clinical Quality
 - Infection Prevention RN
- One member of the governing body
- Optum Legal
- Vice Presidents Clinic Operations
- UHG Safety Regional Manager

Patient Safety Committee Responsibilities_(based on [NRS 439.875](#) and [NRS 439.877](#))

The Patient Safety Committee is a standing confidential interdisciplinary committee formed that manages the Southwest Medical’s Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach

- Evaluating and improving the quality of care rendered by Southwest Medical
- Collecting data and evaluating aggregate data related to individual occurrences in order to utilize performance improvement methodologies to promote patient safety and infection prevention
- Maintaining and improving patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Monitoring and documenting the effectiveness of the patient identification policy
- On or before July 1 of each year, submitting a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#)
- Receiving reports from the Patient Safety Officer pursuant to [NRS 439.870](#)
- Evaluating actions of the Patient Safety Officer in connection with all reports of potential or actual sentinel events
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to improve the safety of patients who receive treatment
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to prevent and control infections
- Making recommendations to the governing body to reduce the number and severity of sentinel events and infections that occur
- At least once each quarter, reporting to the governing body regarding
 - The number of sentinel events at the medical facility (Surgery Centers) during the preceding calendar quarter
 - The number and severity of infections at the medical facility (Surgery Centers) during the preceding calendar quarter
 - Any recommendations to reduce the number and severity of sentinel events and infections

- Adopting patient safety checklists and patient safety policies as required by [NRS 439.877](#), reviewing checklists and policies annually and revising the checklists and policies as necessary
- Directing root cause analysis teams when indicated
- Providing oversight/direction for Surgery Centers QAPI program and quality studies
- Providing oversight/direction for the Surgery Centers participation in NHSN
- Providing oversight and monitoring for the Optum Practice Health and Safety Clinical Assessment Process

Patient Safety Officer Responsibilities ([based on NRS 439.870](#))

- Chair the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#)
- Take such action as necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility
- Report to the Patient Safety Committee regarding any action taken in accordance with the responsibilities above
- Promote compliance with patient safety standards and initiatives
- Reinforce expectations of the Patient Safety Plan
- Accept accountability for measurably improving safety and reducing errors
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors

Infection Prevention Officer Responsibilities ([based on NRS 439.873](#))

- Serve on the Patient Safety Committee
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors
- Provide medical direction as indicated (for both patient and employee infection control issues)
- Monitor the occurrences of infections to determine the number and severity of infections
- Report to the Patient Safety Committee concerning the number and severity of infections
- Take such action as necessary to prevent and control infections alleged to have occurred
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program
- Ensure compliance with current infection prevention and control standards
- Direct infection prevention initiatives
- Reinforce expectations of the Infection Control program
- Complete at least four hours of continuing education each year on topics relating to current practices in infection control and prevention
- Be a certified Infection Preventionist or complete a nationally recognized basic training program in infection control

RCA Team/Meeting

Will meet as needed to:

- Define the healthcare issues or potential risks
- Conduct Root Cause Analysis
- Review and analyze data
- Brainstorm issues or the potential risks by using fishbone diagrams or the 5 *Whys* technique
- Identify the contributing factors
- Develop Corrective Action Plan
- Identify Plan-Do-Check -Act (PDCA) topics

- Discuss and present possible changes in procedure to improve areas indicated
- Identify strengths and areas that need improvement
- Develop strategies, solutions, and next steps

RCA Team Leader Responsibilities

- Organize and coordinate the RCA process
- Assemble and encourage a supportive and proactive team
- Assign investigative and implementation tasks to the team members
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership
- Monitor goals and progress towards completion of the Corrective Action Plans
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements

Root Cause Analysis (RCA) Team Responsibilities

- Root cause interviews, analysis, investigation and corrective action plan implementations
- Participate in the RCA meetings and discussions
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders

Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process
- Develop and foster a safe learning and improving culture
- Provide oversight to healthcare quality improvement processes and teams
- Plan, discuss and generate patient safety goals and activities

Quality Studies -Process Analysis (Surgery Centers)

The Surgery Centers will complete quality studies each year that include:

1. A statement of the purpose of the QI activity that includes a description of the known or suspected problem and explained significance to the SSC
2. Identification of the performance goal against which SSC will compare current performance
3. Description of the data that will be collected in order to determine the SSC's current performance
4. Evidence of Data Collection
5. Data analysis that describes findings about the frequency, severity and source of issue
6. Comparison of the SSC's current performance against identified performance goal
7. Implementation of corrective action
8. Re-measurement to objectively determine whether corrective actions achieved and sustained improvement
9. Implementation of any additional corrective action to achieve and/or sustain improved performance (and plan for on-going re-measurement)
10. Communication of findings to SSC Leadership, The Patient Safety Committee, the Board of Directors and SSC staff and incorporating findings into educational activities

For quality studies, the Surgery Center(s) may base topic selection on information published by accrediting bodies, National Patient Safety Goals and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention and control, patient/family suggestions/expectations or process outcomes

The Surgery Centers quality studies will focus on redesign or implementation of new processes to incorporate patient safety principles and will place an emphasis on the important facility and patient care functions of:

- Rights of Patients
- Governance
- Administration
- Quality of Care
- Quality Management and Improvement
- Clinical Records and Health Information
- Infection Prevention and Control and Safety
- Facilities and Environment
- Anesthesia Services
- Surgical and Related Services
- Pharmaceutical Services
- Pathology and Medical Laboratory Services
- Diagnostic and Other Imaging Services

Infection Prevention Program

- The purpose of the Infection Control Programs is to prevent and control infections
- The Infection Control Program and the surgery Centers Infection Control Program (SSC and SCT 1600-3 Infection Control Program for Southwest Medical Surgery Center) are components of the Patient Safety Plan
- The Infection Control Programs are based on current guidelines developed by nationally recognized infection control organizations
- The Infection Control Professionals will report regularly on the number and severity of infections that occurred in the prior quarter

Infection Prevention RN

Southwest Medical will maintain at least one Registered Nurse with training and education in infection prevention and control. While supporting the entire organization, the Infection Prevention RN will dedicate specific hours to the SSC

NHSN

- The medical facilities (Surgery Centers) will participate in the CDC's National Healthcare Surveillance Network
- Infection Prevention staff will report aggregate data and patient follow-up to the Patient Safety Committee at regularly scheduled intervals

Medical/Health Care Error

- Staff will immediately report the event to supervisor

The supervisor will:

- Immediately communicate the event through appropriate channels to the Patient Safety Officer; should this occur during off-hours, the supervisor/designee will leave a voice mail message for the Patient Safety Officer
- Initiate investigation and follow-up actions
- Staff will complete the Incident/Occurrence Report or Quality of Care form
- Staff will obtain required orders to support the patient's clinical condition
- Staff/supervisor will notify the UHG Safety Liaison of any situations of potential risk to others
- The Patient Safety Officer will follow usual protocols to investigate the error and coordinate the factual information/investigation for presentation, review and action by the Patient Safety Committee and/or other quality committees as applicable

Identification and Reporting

- SMA Policy 1600-29 (Sentinel Event Policy) and SMA Policy 190-4 (Incident Occurrence Reporting Policy) will describe the mechanism for identification and reporting a Sentinel Event/other medical error
- Southwest Medical will promote willingness of staff to report and will support a Just Culture that focuses on process not individuals

Root Cause Analysis

- The Patient Safety Committee/Patient Safety Officer will provide oversight and direction for any root cause analysis of facility processes conducted for either Sentinel Events or near miss events
- The Patient Safety Officer will act as the liaison to quality committees and the Board of Directors for review/recommendations

Staff Involvement

As Southwest Medical actively supports the concept that errors occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

- A non-punitive approach and without fear of reprisal
- Voluntary participation in the root-cause analysis for educational purposes and prevention of further occurrences

Reporting Requirements/Sentinel Event Reporting

- The Patient Safety Officer will direct reporting sentinel events to the Patient Safety Committee
- The Patient Safety Officer will direct reporting of any sentinel event at a medical facility per state of Nevada requirements as defined in NRS (Nevada Revised Statutes) and NAC (Nevada Administrative Code)
- The Patient Safety Officer will direct reporting the number of sentinel events and recommendations to reduce the number or severity of sentinel events to the SMA Board of Directors
- The Patient Safety Officer/Committee will provide education and support to providers to ensure providers report the occurrence of a sentinel event resulting from any surgery to the Board within fourteen days after the occurrence of the sentinel event
- The Patient Safety Committee shall evaluate the actions of the Patient Safety Officer in connection with the reporting of sentinel events
- The Patient Safety Committee shall make recommendations to the SMA Board of Directors to reduce the number and severity of sentinel events and infections that occur at the facility

HealthCare Acquired Infections (HAI) Reporting

The Patient Safety Officer/Committee will provide education and support to providers to ensure if a provider identifies a patient with an infection, the provider will notify, within five days or as soon as practicable, the patient or the legal guardian or other person authorized by the patient to receive such information that the patient has an infection

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand the notification may be delayed if the patient does not have a legal guardian, has not authorized any other person to receive such information and:

- Is not capable of understanding the information
- Is not conscious
- In the provider's judgment, the notification is likely to result in the patient harming himself

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand if the notification is delayed, the information must be provided as soon as practicable after:

- The patient is capable of understanding the information

- The patient regains consciousness
- In the judgment of the provider, the patient is not likely to harm himself if informed about the infection
- A legal guardian or other person authorized to receive such information is available

Internal Reporting

The Patient Safety Committee will report internally to provide a comprehensive view of both the clinical and operational safety activity of the organization by submitting Patient Safety Committee minutes/reports to the SMA Board of Directors

The Patient Safety Committee will include ongoing activities such as data collection and analysis, actions taken and monitoring for the effectiveness of actions

External Reporting

The Patient Safety Committee will report externally in accordance with all state, federal and regulatory body rules, regulations and requirements.

- On or before March 1 of each year, The Patient Safety Committee will submit an annual sentinel event report to the Office of Public Health Informatics and Epidemiology, Bureau of Health Statistics, Planning, Epidemiology and Response, Nevada State Health Division
- The Surgery Centers will participate in the CDC National Healthcare Surveillance Network per State of Nevada NRS and NAC

Annual Report

The Patient Safety Officer will report to the SMA Board of Directors and will include:

- Defining the scope of occurrences including sentinel events, near misses and serious occurrences
- Demonstrating a pro-active component of the patient safety program through selection of high risk or problem prone processes for ongoing measurement and analysis
- Reporting results ongoing measurement and analysis of the high-risk or error-prone processes
- Describing how the function of process design incorporates patient safety using specific examples of process design or redesign that include patient safety principles
- Describing the process for soliciting and obtaining input for improving patient safety from patient/families
- Describing staff willingness to report medical/health care errors
- Describing the procedures for communication with patients/families about adverse events or unanticipated outcomes of care
- Describing examples of ongoing in-service, education and training programs to maintain and improve staff competence and support an interdisciplinary approach to patient care

Medical Facility (Surgery Centers) Reporting Requirements

The Patient Safety Officer/Committee will report to the appropriate licensing Board, within five days, after a change in the privileges of a physician, perfusionist, physician assistant or practitioner of respiratory care that is based on:

- An investigation of the mental, medical or psychological competency of the physician, perfusionist, physician assistant or practitioner of respiratory care
- Suspected or alleged substance abuse in any form by a physician, perfusionist, physician assistant or practitioner of respiratory care

Public Disclosure

The Surgery Centers will provide the name of each physician who performed a surgical procedure at the Surgery Centers, the total number of surgical procedures performed by the physician, reported by type of medical treatment, principal diagnosis, if the information is available, by principle surgical procedure and secondary surgical procedure (SB340)

Objectives Patient Safety Plan

Objective
Encourage organizational learning about medical/health care errors
Incorporate recognition of patient safety as an integral job responsibility
Include patient safety into job specific competencies
Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame
Involve patients in decisions about their health care and promote open communication about medical errors/consequences which occur
Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
Support sharing of knowledge to effect behavioral changes in and within SMA

Components and Methods

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

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



Root Cause Analysis

- A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals
- Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis
- Root Cause Analysis and action plan framework table was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used at Southwest Medical to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

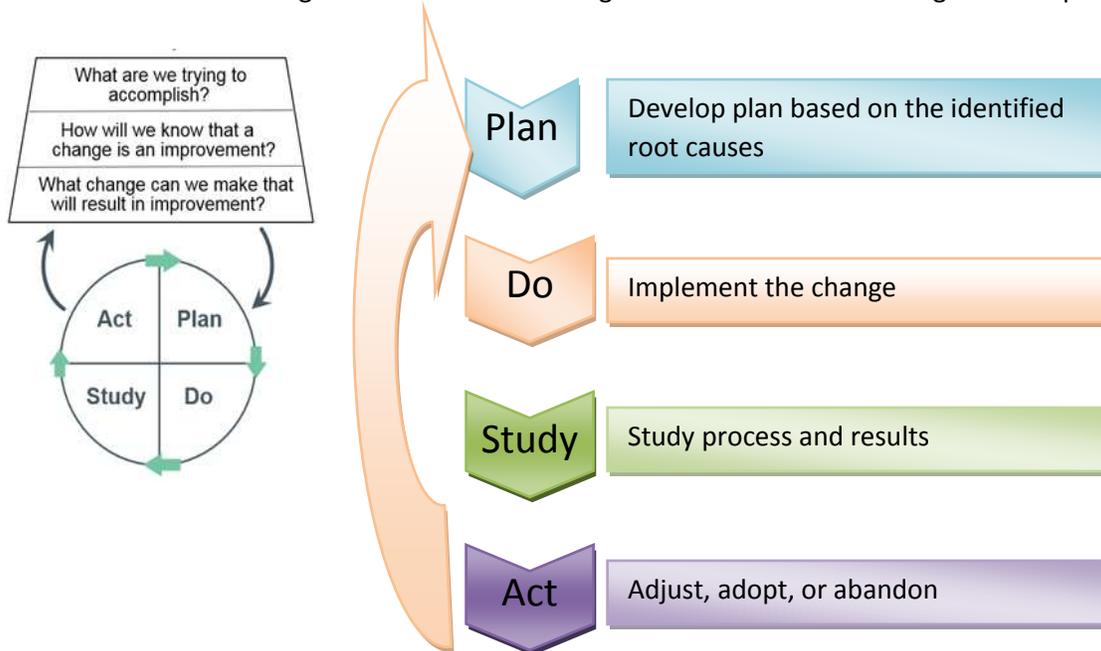
Once the problems are identified, a Fishbone Diagram can be used for analyzing the problems. Southwest Medical can use the fishbone diagram individually to analyze the root causes or can use it with the Root Cause Analysis and action plan framework table

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories include: people, methods, materials, measurements, education, procedures, process, location and environment.

RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions:
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance:
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance:
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Southwest Medical will track sentinel events, healthcare infection data and other internal data collection

External data sources are those data sources which are collected outside the supervisory structure of the case. Southwest Medical may use external data from:

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

Ongoing Reporting and Review

The Patient Safety Committee will review Elements of the Patient Safety Plan at scheduled intervals

Monthly	Quarterly	Annually
<ol style="list-style-type: none"> 1. Sentinel event monthly report 2. Severity of infection report 3. RCA assessment 4. Optum Practice Health and Safety Clinical Compliance and Infection Prevention Clinic Assessments 	<ol style="list-style-type: none"> 1. Incidents-including sentinel event quarterly report 2. Severity of infection report 3. Review and evaluate the measure of improvement of patient safety 4. Review and evaluate the measurement to prevent and control infections 5. Quality reports including: <ul style="list-style-type: none"> • Environment of Care Standards • GI Staff Performance and HLD • Hand Hygiene • Infection Prevention • Sterilization • Pharmacy Standards 	<ol style="list-style-type: none"> 1. Quality and Patient Safety Plan update 2. Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Southwest Medical will review and evaluate the Patient Safety Plan at least annually

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the Patient Safety Plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility
- Other personnel of the facility who provide treatment or assistance to patients
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, environmental services at any medical facility
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary
- A checklist used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications
 - Instructions concerning aftercare
 - Any other instructions concerning his or her care upon discharge
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility

The patient safety policies must include, without limitation:

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

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

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

Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA)

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist

Approval of Patient Safety Plan

According to [NRS 439.865](#), Southwest Medical will submit its Patient Safety Plan to the Governing Board for approval. After the patient safety plan is approved, Southwest Medical will notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan

Southwest Medical will review and update the plan annually in accordance with State of Nevada requirements

Southwest Medical, according to [NRS 439.843](#), will submit the most current copy of the Patient Safety Plan on or before March 1 of each year, to the Division of Public and Behavioral Health

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Terms and Definitions

Patient Safety

The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum
2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:
 - January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or
 - July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published
3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Medical Harm

The Institute for Healthcare Improvement (IHI) defines medical harm as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: (NRS 439.802)

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections
- Ventilator-associated pneumonia
- Central line-related bloodstream infections
- Urinary tract infections
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#)

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical Facility (NRS 439.805)

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near Miss

An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update)

Mandatory Reporting

Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk

Risk is the possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable Event

Preventable event describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infections (CAUTI)

A CAUTI is a urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI)

A CLABSI is a primary bloodstream infection that is associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection

**BATTLE MOUNTAIN GENERAL HOSPITAL
CRITICAL ACCESS HOSPITAL**

535 S. Humboldt Street
Battle Mountain, NV 89820

Developed By: Risk Manager
Department: All Department
Effective: April 9, 2014
Revised: June 30, 2016
Reviewed: March 6, 2019

Page 1 of 4

TOPIC: PATIENT SAFETY PLAN

POLICY:

In compliance with **NRS 439.800-439.890**, Battle Mountain General Hospital shall develop, in consultation with the providers of health care that provide treatment to patients at the medical facility, an internal patient safety plan to improve the health and safety of patients who are treated at this medical facility.

Pursuant to **NRS 439.860**, any report, document and any other information compiled or disseminated pursuant to the provisions of **NRS 439.800-439.890**, inclusive, is not admissible in evidence in any administrative or legal proceeding conducted in this State.

The BMGH Patient Safety Plan must include, without limitation:

- The patient safety checklists and patient safety policies most recently adopted pursuant to **NRS 439.877**.
- An infection control program to prevent and control infections within the medical facility. To carry out the program, the medical facility shall adopt an infection control policy. The policy must consist of:
 - The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization and the Society for Healthcare Epidemiology of America.
 - Facility-specific infection control developed under the supervision of a the person who has successfully completed a nationally recognized basic training program in infection control, which may include, without limitation, the program offered by the Association for Professionals in Infection Control and Epidemiology, Inc.

Reviewed by AA/hh

The program to prevent and control infections within the medical facility must provide for the designation of a person who is responsible for infection control when the infection control officer is absent to ensure that someone is responsible for infection control at all times.

Battle Mountain General Hospital shall submit its patient safety plan to its governing board for approval. After the BMGH Patient Safety Plan is approved, BMGH shall notify all providers of health care who provide treatment to patients at BMGH of the existence of the plan and of the requirements of the plan. BMGH shall require compliance with its patient safety plan. The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

BMGH shall designate an officer or employee of the facility to serve as the patient safety officer of the medical facility. The person who is designated as the patient safety officer shall:

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

BMGH shall establish a patient safety committee.

- The BMGH Patient Safety Committee must be composed of:
 - The patient safety officer of the medical facility.
 - The infection control officer of the medical facility.
 - At least three providers of health care who treat patients at BMGH, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.
 - One member of the executive or governing body of the medical facility.
- A patient safety committee shall meet at least once each month.
- The patient safety committee shall:
 - Receive reports from the patient safety officer pursuant to **NRS 439.870**.
 - Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
 - Review and evaluate the quality of measures carried out by BMGH to improve the safety of patients who receive treatment at the medical facility.

- Make recommendation to the executive or governing body of the medical facility to reduce the number and severity of sentinel events that occur at BMGH.
 - At least once each calendar quarter, report to the BMGH executive or governing body of the medical facility regarding
 - The number of sentinel events that occurred at BMGH during the preceding calendar quarter;
 - The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
 - Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
 - Adopt patient safety checklists and patient safety policies as required by **NRS 439.877**, review the checklists and policies annually and revise the checklists and policies as the patients safety committee determines necessary.
- The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in **NRS 49.265**

The Patient Safety Committee, established pursuant to **NRS 439.875** by a medical facility, shall adopt patient safety checklists and patient safety policies for use by:

- Providers of health care who provide treatment to patients at BMGH;
- Other personnel of the medical facility who provide treatment or assistance to patients;
- Employees of the BMGH who do not provide treatment to patients but whose duties affect the health or welfare of the patients at BMGH, including, without limitation, a janitor of BMGH; and
- Persons with whom BMGH enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at BMGH.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare; and
 - Any other instruction concerning his or her care upon discharge.

- Any other checklists which may be appropriate to ensure the safety of patients at the medical facility

The patient safety policies must include, without limitation:

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

The patient safety committee shall:

- Monitor and document the effectiveness of the patient identification policy adopted.
- At least annually, review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
- Revise a patient safety checklist and patient safety policy as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
- On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if the person, without malice:

- Reports a sentinel event to a governmental entity with jurisdiction or another appropriate authority
- Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event;
- Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority;
- Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or
- Performs any other act authorized to **NRS 439.800-439.890** inclusive.



2019 PATIENT SAFETY PLAN

GOALS

Derived from the mission, vision and values of UHS and West Hills Hospital, the West Hills Hospital Patient Safety Plan is designed to:

- improve patient health and safety;
- provide a frame work that facilitates a culture of patient safety;
- reduce risk of error and harm; and
- Report and act upon avoidable errors, near misses, and injuries during hospitalization and outpatient treatment.
- Review all best practices through alerts and updated standards from all corporate, certification and regulatory bodies.
- Complete Patient Safety Survey

OBJECTIVES

The objectives of the Patient Safety Plan are to:

- Effect behavioral changes that support patient safety, risk reduction, and a living value of respect for the dignity of patients.
- Incorporate recognition of patient safety as an integral job responsibility
- Encourage recognition and reporting of patient care errors, near misses, and risks
- Assure reporting of all sentinel events in compliance with Nevada Revised Statutes (NRS) 439.870
- Assure compliance with NRS 439.875 by adopting/utilizing patient safety checklists.
- At least annually, review the checklists and policies to ensure the checklists or policy reflects the most current standards in patient safety protocols.
- Revise as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
- Assure completion of intensive analysis of all sentinel events using the Joint Commission format and forms, taking into consideration all 6 important variables as potential causes (human, environmental, external, human resources, information management, and leadership)
- Assure development and effective implementation of appropriate action plans resulting from RCA(s).
- Implement and maintain systems which support safe patient care processes and procedures
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions and ongoing monitoring
- Monitor and document the effectiveness of the patient identification policy
- On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau.

- Report internally to the Patient Safety Council/ Committee, MEC and the Governing Board.

PRIORITIES

Priorities for 2019 are:

1. A Patient Safety Council/Committee in compliance with NRS 439.875
2. Review and evaluate the hospital's quality measures in place
3. Reduce the number and severity of sentinel events.
4. Review and modify organizational processes to ensure compliance with the Joint Commission National Patient Safety Goals
5. Analysis of one high-risk process for proactive risk assessment
6. Review annually checklists or policy to ensure the most current standards in patient safety protocols are being adhered to with audit revision.
7. Implement all risk alerts to incorporate best practices to the greatest degree possible into the patient safety process and systems already in place.
8. Review, revise and promote patient-safety orientation and education for employees
9. Communicate WHH patient safety commitment to customers, patients and visitors
10. Report quarterly to the WHH Medical Staff (MEC) and at a minimum of annually to the Governing Board the number of sentinel events that occurred at the medical facility during the preceding calendar quarter; The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility

ORGANIZATION AND FUNCTIONS

The **Patient Safety Council** is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The council will meet monthly, no less than 10 times per year, to assure the maintenance and improvement of Patient Safety. Membership is required to attend 10 of the 12 meetings held during each year.

1. The scope of the Patient Safety Council includes review and analysis of actual and potential patient care errors involving the patient population of all ages, visitors, hospital/medical staff, and students. Data from internal (PI/RM data collection, incident reports, patient/family complaints, patient satisfaction surveys, Core Measure reports, employee and medical staff suggestions, infection Prevention) and external resources (TJC Sentinel Event Alerts, UHS alerts and advisories , customer feedback, licensure and/or accreditation survey results, reports in the literature, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. Best Practices will be researched and reviewed for possible implementation.
2. Definitions related to patient care errors include:

- Adverse Event – Any injury caused by health care; an undesirable outcome resulting from some aspect of diagnosis or treatment
- Error Chain – A series of events leading to an undesirable outcome
- FMEA (Failure Mode Effects Analysis) – A framework for predicting possible errors, particularly process failure, is combined with an estimate of the relative impact of that error to produce a “criticality index”. This index allows for prioritization of quality improvement targets
- Hazardous Conditions – any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome
- Near Miss – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome; a “close call”
- Patient Safety – Freedom from accidental or preventable injuries produced by healthcare
- Root Cause – cause of process variation including (1) failure to follow standard operating procedures; (2) poor leadership; (3) breakdowns in communication or teamwork; (4) overlooking or ignoring individual fallibility; and (5) losing track of objectives.
- Sentinel Event – new definition as of October 1, 2013 per Nevada Revised Statute. An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase “or risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome
- GOOD Catch Program will document and implement strategies to provide a safe environment for our patients.

3. The **Patient Safety Council** will be chaired by the designated **Patient Safety Officer**.

- a. The Patient Safety Council report will be presented by the Director of Performance Improvement / Risk Management.
- b. The responsibilities of the Patient Safety Officer include:
 - i. Serving on the Patient Safety Council/Committee;
 - ii. Supervision of the reporting of all sentinel events alleged to have occurred in the hospital;
 - iii. Taking such action as he/she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event; and
 - iv. Reporting to the Patient Safety Committee regarding any action(s) taken.
- c. Team membership includes (as required by law) in Nevada NRS: at least 3 healthcare providers, including a minimum of one member of the medical

staff, nursing, and pharmaceutical staff of the hospital, the infection preventionist (as required by NRS) and one member of the Governing Board. The CEO and Patient Safety Officer also will be voting members, as required by law. Other organization leaders will be invited to participate on an as-needed basis.

4. The mechanism to insure all components of the organization are integrated into the program is via a collaborative effort throughout the hospital and outpatient services.

This is accomplished by:

- Reporting of potential or actual occurrences through the Incident Reporting system utilizing the Healthcare Peer Review (HPR) format by any employee in all departments.
 - Analysis of complaints or suggestions from patients and families.
 - Obtaining employee and medical staff suggestions for improvements via Process Improvement submissions.
 - Integration of Infection Prevention data in coordination with the infection preventionist.
 - Consideration of ages and developmental levels of the patient populations.
 - Communication between the Patient Safety Officer and the Environment of Care Safety Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.
 - Reporting of patient safety measurements to the performance improvement coordinating and oversight group.
 - Review of processes, policies and systems in place as alerts and recommendations are received through UHS/TJC/CMS and NRS.
5. A proactive component of the program includes annual selection of at least one high risk or error prone process for concentrated activity, ongoing measurement and periodic analysis. The selection may be based on information published by TJC Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality control, infection control, patient/family suggestions/expectations or process outcomes. The Primary initiative will be the discharge process. The discharge planning process will begin on admission and multidisciplinary staff compiles information to affect a safe discharge plan.
 6. The following **Patient Safety Measures** will be the focus of 2019 Patient Safety activities:
 - Observation Rounds
 - Discharge Process
 - Multiple Incident Review Reports
 - Near-Miss Analysis

- PsychSafe Clinical/Risk Dashboard - Facility trends/benchmarks
 - MIDAS: HPR Trend Reports
 - Patient Safety Advisory – Facility Action Plans
 - MIDAS: Good Catch Reports
 - Healthcare Acquired Infections; report as necessary per the Sentinel event definition adopted in October 2013. Event related reports are submitted when required.
 - Sentinel Event Reports (including any reportable patient event as they occur)
 - Staff Patient Safety Culture Survey results annually with a plan for improvement.
7. Solicitation of input and participation from patients and families in improving patient safety will be accomplished by:
- a. Patient / family complaints or suggestions
 - b. Comments from Patient Satisfaction surveys
8. Methods to assure ongoing education and training programs for maintenance and improvement of staff competence for safe patient care were implemented in 2013 and will be monitored again in 2019 as evidenced by:
1. Orienting new staff members to WHH values and patient safety commitment and providing information on reporting mechanisms in the orientation training
 2. Providing ongoing education through education sessions, departmental meetings and/or other administrative communications, in-services and meetings
 3. Evaluating staff knowledge levels of patient safety principles through Health stream program and contributions to patient safety in annual performance appraisals
9. Internal accountability for an effective patient safety program will be demonstrated via reporting to and oversight of the activities and results of the Patient Safety Council to the Medical Executive Committee and to the Governing Board.
10. A separate Environment of Care committee that addresses EOC safety considerations was instituted as a separate group in 2013 and will continue in 2019.
11. External Reporting: External reporting will be completed in accordance with all state, federal, and regulatory body rules, regulations and requirements.
12. An **annual evaluation** of the effectiveness of the Patient Safety Plan will be conducted and reported to the Medical Executive Committee and Governing Board and will include:
- a. The results of efforts to create and maintain a just and fair culture throughout the organization.

- b. The scope of occurrences including sentinel events, near misses and serious occurrences and the effectiveness of actions taken to prevent recurrence.
 - c. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected.
 - d. Performance results of the high-risk or error-prone processes selected for measurement and analysis.
 - e. The results of input are solicited and participation from patients and families in improving patient safety is obtained and incorporated into the patient safety program.
 - f. A description of the procedures used and examples of communication occurring with families about adverse events or unanticipated outcomes of care, if applicable during the reporting period.
 - g. A description of ongoing staff education and training programs that are maintaining and improving staff patient safety competence, participation in patient safety activities, and error reporting. Recommendation for any indicated modification of the program organization or functions including incorporation of recognized advancements in patient safety practices.
12. Evaluation or modification of the plan may be undertaken more often than annually if indicated.
13. The facility's Disaster Response efforts will be incorporated into the overall patient safety efforts of the facility. The Disaster Preparedness approaches will be examined in light of patient safety considerations. The Patient Safety Officer will be charged with evaluating actual or potential patient safety issues arising during a disaster and reporting these to the PI Committee.

 Boulder City Hospital Quality care close to home	Patient/Resident Safety Plan		
	DEPARTMENT: Administration		
APPROVED BY:	REFERENCE # SEP 015	Page 1 of 7	
EFFECTIVE: 9/18/2007	REVIEWED:	REVISED: 01/26/10; 12/21/2010, 6/1/11; 10/13/14; 9/20/16;9/28/18	

PURPOSE:

- I. The purpose of the Patient/resident Safety Plan (PRSP) is to improve patient safety and reduce risk to patient/residents through an environment that promotes:
 - a. Recognition and acknowledgment of risks to patient safety and medical/health errors;
 - b. The initiation of actions to reduce these risks;
 - c. The internal reporting of findings and the actions taken;
 - d. A focus on processes and systems;
 - e. Minimization of individual blame or retribution for involvement in a medical / health care error;
 - f. Organizational learning about medical/health care errors and safety factors;
 - g. Support of the sharing of knowledge to effect behavioral changes within Boulder City Hospital (BCH)
 - h. Individual responsibility to identify report and participate in the solution of safety risks.

POLICY:

NOTE: The term Patient will be used throughout this policy to represent patients, residents and clients.

- I. The PRSP provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through:
 - a. The establishment of mechanisms that support effective responses to actual occurrences;
 - b. Ongoing proactive reduction in medical / health care errors; and
 - c. Integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
 - d. Zero tolerance for workplace violence. BCH strives to maintain a harmonious work environment free from violence and intimidation. Weapons of any kind are prohibited. Violent acts, threatening, harassing, discriminating, disruptive behavior (conflict that disrupts the work and jeopardizes the safety of individuals) and/or coercing behavior are prohibited and may result in disciplinary action up to and including termination (for employees) and/or legal action as warranted.
- II. As patient care and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the activities to maintain patient safety. This plan works in conjunction with the facility-wide Safety/Emergency Preparedness Manual which has inter-facility and department specific policies as necessary to address safety concerns such as Fire, Emergency Preparedness for Internal and External Disasters, Pandemic Events, etc.
 The PRSP was developed by the interdisciplinary Safety Committee and approved by the Medical Staff, Board of Trustees and Administration and outlines the components of the organization's PRSP.

PROCEDURE:

- I. Scope of Activities
 - a. Ongoing assessment, monitoring, tracking and trending with analysis using internal and external knowledge and experience to:
 - i. Prevent error occurrence
 - ii. Maintain and improve patient safety
 - b. Patient/resident Safety Occurrence Information:
 - i. Collected from aggregated data reports and individual occurrence reports.
 - ii. Will be reviewed by the Safety Committee.
 - iii. Is used to prioritize organizational patient safety activity efforts.
- II. Types of Patient/resident Safety or Medical/Health Care Errors

 Boulder City Hospital Quality care close to home	Patient/Resident Safety Plan		
	DEPARTMENT: Administration		
APPROVED BY:	REFERENCE # SEP 015	Page 2 of 7	
EFFECTIVE: 9/18/2007	REVIEWED:	REVISED: 01/26/10; 12/21/2010, 6/1/11; 10/13/14; 9/20/16;9/28/18	

- a. No Harm Errors
 - i. Unintended acts, either of omission or commission;
 - ii. Acts that do not achieve their intended outcome; and/or
 - iii. Acts that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, to the patient
- b. Mild to Moderate Adverse Outcome Errors
 - i. Any medication error (mindful of the errors that result from: incomplete and/or inaccurate medication orders, transcription and documentation; not adhering to the 5 rights of medication administration; inappropriate labeling as well as in appropriate monitoring and storage of medications)
 - ii. Any Adverse Drug Reaction (ADR)
 - iii. Any transfusion reaction
 - iv. Hazardous Condition
 - 1. Any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
 - v. Any Healthcare Associated Infection (HAI) including but not limited to Central Line Associated Blood Infections (CLABSI); Catheter Related Urinary Tract Infections (CAUTI); c-diff infections
 - vi. Any Health care Associated Stage III or IV Pressure Ulcer
 - vii. Any patient fall with injury
 - viii. Any patient aspiration
 - ix. Any motor vehicle accident wherein a patient was a passenger
- c. Sentinel Event (SE):
 - i. Unexpected adverse occurrence involving death or serious injury or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. A sentinel event is an adverse event of a severe and urgent nature that can result in an unexpected and undesirable patient outcome. (Example: Surgery on the wrong patient or removal of the incorrect limb) The phrase "the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. A Sentinel Event: (Refer to BCH Policy, "Sentinel Events")
 - ii. Potentially involves a continuing threat to patient care or safety
 - iii. Has significant potential for being reflective of serious underlying systems problems within an organization
 - iv. Potentially undermines public confidence in the organization
 - v. A "Near Miss" is any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Refer to BCH Policy, "Sentinel Events" For this policy, all reference to Sentinel Events includes Near Miss events as well.

III. Scope of Program

- a. Encompasses:
 - i. Patient, resident and client population;
 - ii. Visitors;
 - iii. Volunteers; and
 - iv. Staff (including Medical Staff)
- b. Addresses:
 - i. Maintenance and improvement in patient/resident safety issues in every department throughout the facility
 - ii. Emphasizes hospital and patient care functions of:

 Boulder City Hospital Quality care close to home	Patient/Resident Safety Plan		
	DEPARTMENT: Administration		
APPROVED BY:	REFERENCE # SEP 015	Page 3 of 7	
EFFECTIVE: 9/18/2007	REVIEWED:	REVISED: 01/26/10; 12/21/2010, 6/1/11; 10/13/14; 9/20/16;9/28/18	

Ethics, Rights & Responsibility
 Provision of Care
 Medication Management
 Improving Organization
 Performance
 Leadership

Management of the Environment of Care
 Management of Human Resources
 Management of Information
 Surveillance, Prevention and Control of
 Infection

c. Assures:

- i. All departments have current Safety Manual available on-line
- ii. Emergency Preparedness Quick Reference Guide “Red Book” is available in high traffic areas
- iii. Senior Leaders are FEMA trained and NIMS compliant
- iv. Hospital Decontamination Program (and related equipment) is available and compliant with current regulations
- v. Enforced Hand Hygiene policy
- vi. Adherence to Standard Precautions with implementation of Isolation Precautions when necessary
- vii. Maintenance of a sanitary environment through interdepartmental collaboration, product and service evaluation and monitoring effectiveness

IV. Methodology

a. Responsibility

- i. The Committee meets monthly and is responsible for oversight of the Patient/resident Safety Program
- ii. The Patient Safety Officer will have Administrative responsibility for the program

b. Membership will include but not be limited to:

- | | |
|---|--|
| i. Safety Officer | viii. Acute Nursing Services Representative |
| ii. Physician | ix. Purchasing/Central Supply Representative |
| iii. Chief Nursing Officer/Patient Safety Officer | x. Environmental Services Representative |
| iv. Pharmacy Staff Representative | xi. Chief Executive Officer |
| v. Human Resources Representative | xii. Risk Manager |
| vi. Laboratory Representative | xiii. Infection Control Nurse |
| vii. Long Term Care Representative | xiv. Program Manager |

c. Communication

- i. **All departments**, both patient care and non-patient care are responsible to report patient safety occurrences and potential occurrences to the Risk Manager. Through the Quality Reporting and Resolution system (QRR)
- ii. Risk Manager will aggregate occurrence information and present a report to the Committee on a quarterly basis.
- iii. The report will contain aggregated information related to:
 1. Type of occurrence;
 2. Severity of occurrence;
 3. Number/type of occurrences per department;
 4. Occurrence impact on the patient;
 5. Remedial actions taken; and
 6. Patient/resident outcome.
- iv. The Committee will:
 1. Analyze the report information; and
 2. Determine further patient safety activities as appropriate.

 Boulder City Hospital Quality care close to home	Patient/Resident Safety Plan		
	DEPARTMENT: Administration		
APPROVED BY:	REFERENCE # SEP 015	Page 4 of 7	
EFFECTIVE: 9/18/2007	REVIEWED:	REVISED: 01/26/10; 12/21/2010, 6/1/11; 10/13/14; 9/20/16;9/28/18	

- v. The Committee will make recommendations for action and implementation and will follow-up as appropriate. Safety information is relayed to Department Managers, the Medical Executive Committee and the Board of Trustees who will then share the information during meetings and/or through communiqués.

V. Review of Internal and External Reports

- a. To include, but not be limited to:
 - i. Sentinel event report information;
 - ii. HAI statistical report;
 - iii. Fire and Disaster Drill reports;
 - iv. Occurrence reporting;
 - v. Injury Report;
 - vi. Information from state and federal sources;
 - vii. Current literature;
 - viii. Performance Improvement reports.
 - ix. Safety Survey results (performed at least annually)
- b. The Committee will select at least one high-risk safety process for an annual proactive risk assessment.
- c. The proactive risk assessment will include:
 - i. Assessment of the intended and actual implementation of the process.
 - ii. Identify the steps in the process if there may be any undesirable variations.
 - iii. Identification of possible effects of the undesirable variation on patient/residents.
 - iv. How serious the possible effects on the patient/resident could be.
 - v. For the most critical effects, conduct a failure mode event analysis (FMEA) to determine why the undesirable variation leading to that effect may occur.
 - vi. Redesign the process and/or underlying systems to:
 - 1. Minimize the risk of that undesirable variation; or
 - 2. Protect patient/residents from the effects of that undesirable variation.
 - vii. Test and implement the redesigned process.
 - viii. Identify and implement measures of the effectiveness of the redesigned process.
 - ix. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

VI. Identification of a Medical/Health Care Error

- a. Note that the following Quality Improvement Policies are pertinent to this section: Medication Errors [HWN 139], Decreasing Medication Errors [HWN 142] and Safe Medication Practices [HWN 145]
- b. The staff member will immediately:
 - i. Perform and/or obtain necessary healthcare interventions to protect and support the patient's clinical condition;
 - ii. As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of any recalled item from stock.
 - iii. Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary;
 - iv. Preserve any information related to the error including physical information such as:
 - 1. Removal and preservation of blood unit for a suspected transfusion reaction;
 - 2. Preservation of IV tubing, fluids bags and/or pumps for a patient/resident with a severe drug reaction from IV medication;
 - 3. Preservation of medication label for medications administered to the incorrect patient/resident;
 - 4. Documenting the facts regarding the error in the medical record as appropriate to organizational policy and procedure;
 - 5. Reporting the medical/health care error to Department Director; and

 Boulder City Hospital Quality care close to home	Patient/Resident Safety Plan		
	DEPARTMENT: Administration		
APPROVED BY:	REFERENCE # SEP 015	Page 5 of 7	
EFFECTIVE: 9/18/2007	REVIEWED:	REVISED: 01/26/10; 12/21/2010, 6/1/11; 10/13/14; 9/20/16;9/28/18	

6. Enter the occurrence report into the Quality Review Report system. Risk Manager will review.

- c. Any individual in any department identifying a potential patient safety issue will:
 - i. Immediately notify his/her supervisor; and
 - ii. Document the findings in QRR system.
- d. Patient, and family member as appropriate; and officiating agency will be notified timely of safety concerns and/or medical errors including HAI, ADR, SE, etc.

VII. Response

- a. Staff response to medical/health care errors is dependent upon the type of error identified.
- b. Error types:
 - i. Near miss
 - 1. Report the near miss event to immediate supervisor;
 - 2. Describe the facts of the near miss in the QRR System
 - ii. No harm errors (including "no harm" medication errors)
 - 1. Document appropriately in the medical record according to policy;
 - 2. Document the circumstances regarding the no harm error in the QRR system; and
 - 3. Notify the immediate supervisor.
 - iii. Mild to moderate adverse outcome errors (including medication errors)
 - 1. Perform any necessary clinical interventions to support and protect the patient/resident;
 - 2. Notify the physician and staff responsible for the patient/resident;
 - 3. Carry out any necessary physician orders;
 - 4. Preserve any physical evidence as appropriate;
 - 5. Notify immediate supervisor;
 - 6. Document facts appropriately in the medical record and in the QRR system.
 - iv. Adverse Drug Reaction
 - 1. Perform any necessary clinical interventions to support and protect the patient;
 - 2. Notify the physician staff responsible for the patient;
 - 3. Execute any necessary physician orders;
 - 4. Preserve any physical evidence as appropriate;
 - 5. Notify immediate supervisor;
 - 6. Document facts appropriately in the medical record and in the QRR system;
 - 7. Report ADR to Pharmacy via an ADR form; and
 - 8. Notify patient/resident and/or family
 - v. Transfusion Reaction
 - 1. Perform any necessary clinical interventions to support and protect the patient;
 - 2. Notify the physician responsible for the patient;
 - 3. Carry out any necessary physician orders.
 - 4. Follow the Administration of Blood and/or Blood Products and the Adverse Reaction to Blood Transfusion policies in House Wide P & P Manual including completion of a QRR
 - vi. Hazardous Condition Patient Safety Issue
 - 1. As appropriate, and if possible, staff will:
 - a. Contain the hazardous condition or patient safety issue;
 - b. Immediately notify supervisor;
 - c. Document the findings in the QRR System;
 - d. Notify patient
 - e. Notify agencies as appropriate
 - 2. BCH has identified three significant clinical safety concerns based on the age of the population we serve and the historical data analyzed:
 - a. Falls with injuries

 Boulder City Hospital Quality care close to home	Patient/Resident Safety Plan		
	DEPARTMENT: Administration		
APPROVED BY:	REFERENCE # SEP 015	Page 6 of 7	
EFFECTIVE: 9/18/2007	REVIEWED:	REVISED: 01/26/10; 12/21/2010, 6/1/11; 10/13/14; 9/20/16;9/28/18	

- b. Aspiration
- c. Hospital Acquired Infection
- 3. For significant safety concerns, BCH has established:
 - a. A mechanism to identify individuals at risk
 - b. Plans to prevent the occurrence of these safety concerns
 - c. A reporting mechanism using the Quality Review and Report system (internal) to track , trend and analyze data reporting to the appropriate internal committees including the Safety Committee, Quality Improvement Committee, Medical Quality Improvement Committee, Medical Executive Committee, and the Board of Trustees
 - d. Timely forward reporting of pertinent information to applicable agencies including but not limited to the State of Nevada Bureau of Health Care Quality and Compliance, the Ombudsman, the Sentinel Event Registry, the Southern Nevada Health District, etc.
 - e. At a minimum annual staff education regarding these safety concerns

vii. Sentinel Event

- 1. Perform any necessary clinical interventions to support and protect the patient;
- 2. Notify the physician and staff responsible for the patient;
- 3. Carry out any necessary physician orders; and
- 4. Notify the patient documenting notification;
- 5. Follow the Sentinel Event Policy and Procedure (see BCH Policy “Sentinel Events” in House Wide P & P Manual).
- 6. Report event to the appropriate committees including Safety, Quality Improvement and Medical Quality Improvement, Medical Executive and Board of Trustees

VIII. Organizational Response

- a. Established policy and/or the Hospital Quality Improvement Committee will determine the organizational response to medical/health care errors and occurrences.
- b. Sentinel events and “Near Misses” will have a root-cause analysis conducted.
- c. The Committee, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
 - i. Further remedial action activities necessary for identified occurrences;
 - ii. Proactive occurrence reduction activities; and
 - iii. Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities.
- d. Resolution
 - i. Non-Punitive Approach
 - 1. An effective Patient/resident Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences.
 - 2. The intent of this institution is to adopt a non-punitive approach in its management of errors and occurrences.
 - 3. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment.
 - 4. This organization supports the concept that errors occur due to a breakdown in systems and processes.
 - 5. Focus will be given on improving systems and processes rather than disciplining those responsible for errors and occurrences.
 - 6. A focus will be placed on remedial actions to assist rather than punish staff members.
 - 7. The Committee and the individual department Managers will determine the appropriate course of action to prevent error recurrence.

 Boulder City Hospital Quality care close to home	Patient/Resident Safety Plan		
	DEPARTMENT: Administration		
APPROVED BY:	REFERENCE # SEP 015	Page 7 of 7	
EFFECTIVE: 9/18/2007	REVIEWED:	REVISED: 01/26/10; 12/21/2010, 6/1/11; 10/13/14; 9/20/16;9/28/18	

- ii. Sentinel Events
 1. Staff members involved in a sentinel event occurrence will receive support to facilitate the staff member's professional and emotional reconciliation of the sentinel event.
 2. The staff member will be allowed an active role in process resolution as well as the root-cause analysis and action plan processes.
 3. Any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling as per the Sentinel Event Policy and Procedure and Employee Assistance Program.
- e. Evaluation
 - i. The Patient/Resident Safety Program includes an annual survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient/resident safety.
 - ii. In keeping with a non-punitive philosophy designed to encourage reporting and resolution of errors, the staff will be queried annually regarding safety concerns including their willingness to report medical/health care errors.
- f. Education
 - i. Staff will receive education and training:
 1. During their initial orientation process; and
 2. On an ongoing basis regarding job-related aspects of patient safety.
 - ii. Education and training will include:
 1. The need and method to report medical/health care errors and other safety concerns;
 2. Providing the optimal provision of healthcare in an interdisciplinary manner; and
 3. An interdisciplinary approach to patient care.
- g. Reporting
 - i. BCH values transparency working together as an organization accountable to the licensing and quality agencies as well as to our patients, staff, medical staff, volunteers and our community
 - ii. Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally per hospital policy and through the channels established by this plan.
 - iii. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Refer to House wide policy HWN 135 Reportable Events.
 - iv. Patient safety reports from the Safety Committee will be submitted to the Medical Executive Committee and the Quality Improvement Committee.
 - v. The Board of Trustees has the opportunity to review and ask questions during the monthly meeting as the minutes of committees are contained within the Medical Executive Committee minutes for approval by the board.

Title: Banner Health System Quality and Safety Plan	
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Effective: 10/10/2017	Last Review/Revision Date: 06/15/2018
Next Review Date: 06/15/2019	Author: Jill Howard (Care Management)
Approved by: Banner Health Board of Directors Quality Committee, Banner Health Board of Directors, Chief Clinical Officer, Clinical Leadership Team, Harm Avoidance Team, PolicyTech Administrators 10/10/2017	
Discrete Operating Unit/Facility: Banner Baywood Medical Center Banner Behavioral Health Banner Boswell Medical Center Banner Casa Grande Medical Center Banner Churchill Community Hospital Banner Del E Webb Medical Center Banner Desert Medical Center Banner Estrella Medical Center Banner Fort Collins Medical Center Banner Gateway Medical Center Banner Goldfield Medical Center Banner Heart Hospital Banner Ironwood Medical Center Banner Lassen Medical Center Banner Payson Medical Center Banner Thunderbird Medical Center Banner—University Medical Center Phoenix Banner—University Medical Center South Banner—University Medical Center Tucson Community Hospital East Morgan County Hospital McKee Medical Center North Colorado Medical Center Ogallala Community Hospital Page Hospital Platte County Memorial Hospital Sterling Regional MedCenter Washakie Medical Center	Banner Corporate Banner Health Clinics Banner MD Anderson Cancer Center Banner Health Network Banner Home Care and Hospice Banner Plan Administration Banner Pharmacy Services Banner Surgery Centers Banner Urgent Care Centers Occupational Health/Employee Services Post-Acute Care Services Research Rural Health Clinics University Physicians Health Plans

I. Purpose/Population:

- A. The purpose of the Banner Health Quality and Safety Plan is by design to outline Banner Health's commitment and systematic approach to quality and patient safety at all levels of the organization consistent with its Mission, Values, and Purpose. Banner Health's quality goal is to continuously improve and increase reliability of our processes and outcomes for the safety and betterment of our patients and other customers, our providers, our partners, our communities and ourselves.
- B. **Population:** All Employees.
- C. **Mission:** Making health care easier, so that life can be better.
- D. **Values:**
 - 1. **Customer Obsessed**
 - a. Puts the need of the customer and team at the center of decision making
 - b. Demonstrates empathy and compassion
 - c. Seeks to consistently enhance interactions and experience by exceeding customer and team members expectations
 - d. Thinks creatively about solutions and takes ownership
 - e. Is passionate about exceptional patient care
 - 2. **Relentless Improvement:**
 - a. Takes action that influences and motivates others
 - b. Instills positive energy and builds a shared vision and purpose
 - c. Ensure that the results of the collective effort aligns with objectives and goals
 - d. Uses data to drive streamlined decision making while also considering the impact on our Mission, people and culture
 - e. Effectively utilizes the organization's decision making process and knows when to collaborate, question or empower
 - 3. **Courageously Innovate**
 - a. Identifies opportunities to create value by introducing new ideas and driving change
 - b. Sees possibilities that don't currently exist Takes risks and challenges the status quo with the intent to strengthen team and organizational performance
 - c. Leverages knowledge and technology to enrich the patient and team member experience and facilitate speed, simplicity and efficiency
 - 4. **Disciplined Focus**
 - a. Is able to assess what is important, balances priorities and creates a clear and effective plan to drive desired outcomes
 - b. Uses time management effectively and measures progress
 - c. Embodies selflessness by always making the team and our Mission the first priority
 - d. Is constantly learning, adapting and paying attention to details
 - 5. **Foster Accountability**
 - a. Takes responsibility and ownership for work
 - b. Actively resolves problems individually and as part of team
 - c. Addresses performance issues with systems and people as opportunities to achieve excellences
 - d. Recognizes and reinforces success and establishes processes for sustainability
 - e. Maintains a team focus and role models servant-leadership
 - 6. **Continuously Earn Trust**
 - a. Fosters strong and authentic relationships in every interaction by demonstrating honesty, respect and assuming positive intent.
 - b. Actively listens to the needs of others, and follows through on commitments

- c. Creates an open culture of communication that honors the truth and values diverse input

E. Purpose:

1. Banner can and will create a new model that answers America's health care challenges today and in the future.
2. Inspired to change the health care landscape in our communities – big and small – our talented and passionate teams care deeply about individuals who are responsive for the needs of their extended families.
3. Taking access and delivery from complex to easy, from costly to affordable and from unpredictable to reliable, we give every individual we serve confidence in their health care experience and its outcome.

II. Definitions:

- A. Facility – Any Banner Health hospital, ambulatory surgery center, physician/provider office, home health, hospice, skilled nursing facility, clinic or other setting where care is provided.
- B. Process Owner – A process owner is an individual responsible for their respective level of business operations. A level of business operation could include a whole Facility, a department or a specific service within a department or across a Facility or the organization.
- C. Process Improvement (PI) – Process Improvement is a series of actions taken to identify, analyze and improve existing processes to meet new goals and objectives.
- D. Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management Program Activities – For the purpose of this plan, “Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management Program” means activities designed and implemented to improve the delivery of care and services.

III. Policy:

- A. Banner Health bases its decisions on its values and applies the Guiding Principles throughout the organization in its Quality Management Model. (See **Figure 1: Banner Quality and Safety Management Model**)
- B. Quality Authority/Responsibility
 1. Governance.
 - a. The Banner Health Board of Directors has the ultimate responsibility and accountability for quality of care and services provided by Banner Health. The Clinical Leadership Team and the Care Management and Quality Committee of the Board serve as the oversight bodies for quality management and have the following duties and delegated responsibilities:
 - i. Monitor non-financial measures of organizational quality performance.
 - ii. Ensure use of a systematic approach to quality management and assess ongoing improvement in the quality of services delivered by the corporation.
 - iii. Review and make recommendations to the Board regarding a system-wide quality plan.
 - iv. Evaluate and make recommendations to the Board concerning healthcare technologies including, but not limited to, genomics, biotechnology, future clinical services delivery and therapeutics.

- v. Evaluate and make recommendations to the Board with respect to ethical implications relating to the activities and services of the corporation, including quality and clinical innovation.
 - vi. Act for the Board with respect to proposals of management and the local institutions and their medical staffs concerning medical staff policies, patient care policies, and compliance with standards of government and accreditation agencies having jurisdiction over the corporations' institutions as to such policies which require the involvement of the Board of Directors.
 - vii. Act for the Board of Directors on matters and activities pertaining to the medical staffs of each local institution operated by the corporation to the extent permitted by law and applicable accreditation standards, including any matter which requires action by the Board of Directors, including the adoption, amendment or repeal of medical staff bylaws, rules and regulations, and medical credentialing criteria.
 - viii. Act for the Board of Directors to the extent permitted by law and applicable accreditation standards, and otherwise make recommendations to the Board of Directors on any matter affecting medical staff membership or privileges, including application for appointment to the medical staff; application for reappointment to a medical staff; request for delineated clinical privileges; and denial, curtailment, limitation or revocation of any of the foregoing.
 - ix. Review reports regarding the quality of care being provided in respective Facilities.
 - x. Perform such other duties and responsibilities as the Board may assign to the Committee from time to time.
- b. In some communities, Advisory Boards provide advice and counsel to management and medical staff leadership on a variety of issues, including quality and safety activities and outcomes.
2. Leadership.
- a. Leadership is responsible for setting organizational direction and does this through the establishment of mission, values, and purpose, including annual initiatives. These are turned into actions through the development and execution of the strategic and operational plans that include quality of services and patient safety. Senior leadership communicates organizational direction, reviews and approves plans, provides resources and structure for the execution of the plans, and reviews performance to meet the goals of the plan.
 - b. At Banner Health, Care Management provides oversight for improvement of clinical care and patient safety coordinated across the system. The Clinical Leadership Team, a group of Banner Health Leaders representing patient care and supporting functions, makes decisions related to system-wide quality and safety goals and activities to achieve those goals.
 - c. Leadership for Facility activities related to quality of services and patient safety is directed by Facility administrative teams working with leaders under the oversight of the Quality Council structure. (See **Figure 2: Banner Facility Quality and Safety Structure Template**)
 - d. Quality Councils are responsible for the oversight of:
 - i. Quality leadership:
 - (i) Development and prioritization of Facility quality and patient safety goals and targets in an annual work plan.
 - (ii) Facilitation of ongoing quality and patient safety education
 - (iii) Communication of the quality and patient safety commitment, goals, targets and performance.

- (iv) Alignment of policies with quality and patient safety commitment.
 - (v) Establishment of an engaged workforce.
 - ii. Quality management:
 - (i) Identification of patients and other customer needs.
 - (ii) Identification of key processes; standardization and simplification.
 - (iii) Establishment of measures and monitoring.
 - (iv) Assessment and analysis of processes and outcomes.
 - (v) Identification of improvement opportunities.
 - iii. Performance improvement:
 - (i) Evaluation and prioritization of improvement opportunities.
 - (ii) Identification and replication of proven or evidence-based practices.
 - (iii) Clinical Innovation through the rapid identification and deployment of strategies based on the science of care delivery.
 - (iv) Allocation of resources for improvement.
 - (v) Celebration of success.
 - iv. Evaluation
 - (i) Evaluation of this plan occurs at the local and system levels. Locally, each Facility reviews its progress towards goals identified in the annual work plan using data that measures clinical, financial, resource utilization, and service performance. To assure sustained improvement, this process includes a review of how improvements have been made and will be maintained. Additionally, leaders evaluate their own performance in supporting sustained improvement. Areas failing to meet targets become areas of focused improvement activities. At the system level, performance information is regularly aggregated for review by leadership and governance.
- 3. Process Owner/Department Managers.
 - a. Process owners, individuals who serve in a leadership role in the performance of a process, are responsible for understanding patient and other customer needs, analyzing the processes used to meet those needs, standardizing and simplifying them to reduce variation and waste, measuring important indicators, and using this data to determine appropriate improvement actions based on the organization's goals.
- 4. Employees, Contacted Staff and Volunteers.
 - a. To assure that the organization meets the needs of its patients and other customers as they interact with nursing and other clinical staff as well as support staff, leadership has committed to developing an engaged workforce (staff, contracted staff and volunteers) who:
 - i. Understand job expectations and responsibilities, including service standards;
 - ii. Have access to information to determine if patient and other customer needs are being met, and understand how to respond quickly to resolve problems.
 - iii. Are provided opportunities and skills for meaningful involvement in improving operations;
 - iv. Recognize the need to work together to meet patient and other customer needs; and
 - v. Know how to identify and report incidents.
- 5. Medical Staff
 - a. Providers fulfill their Medical Staff delegated peer review responsibilities and take a leadership role in quality and patient safety activities. Medical Staff Departments and Committees routinely review clinical performance measures and identify

- improvement opportunities. Medical Staff leaders partner with administration in the leadership of quality management through routine interaction with administrative leaders and also serve on Quality Councils. In addition, providers serve in various capacities as team members, collaborating with other members of the health care team, to monitor and improve processes.
- b. The Board of Directors has delegated responsibility for review of professional practices to the medical staffs as set forth in the Medical Staff Bylaws. The Medical Executive Committees report on their performance of these responsibilities to the Board through the Medical Staff Subcommittee of the Care Management and Quality Committee of the Banner Health Board.
6. Risk Management
 - a. Risk Management conducts activities intended to improve the quality of care and reduce errors and omissions. Risk Management may report trends and concerns relating to individual physicians and allied health providers to the appropriate Medical Staffs to determine whether peer review is warranted. Risk Management may report other trends and concerns to the appropriate subcommittee of the Clinical Leadership Team.
- C. Quality management is initiated as leadership sets organizational direction by planning and developing goals, including quality, patient safety and risk priorities that are based on continuous efforts to understand the needs of those we serve as well as improving current levels of performance, utilizing evidence-based and best practices and industry benchmarks. Areas identified for improvement and for achievement of the vision are called strategic initiatives. Strategic and operational planning processes as well as proactive risk assessment and gap analyses are used to identify desired outcomes and actions to achieve those goals at various levels of the organization. Criteria used for establishing priorities may include, but are not limited to, clinical quality, patient safety, customer satisfactions, strategic direction, financial sustainability, regulatory and accreditation compliance, resource utilization, high volume, high risk, or problem prone areas and external forces.
 - D. Process owners are expected to identify patient and other customer needs and expectations, understand key processes and safe practices, and establish performance measures for their areas of responsibility. Performance measures encompass different dimensions, including clinical outcomes, patient safety, evidence-based practice, utilization management, and patient satisfaction as well as financial sustainability, and are aligned from the system level (e.g., quarterly patient satisfaction with inpatient care) to the process level (e.g., daily feedback from patients in a nursing unit).
 - E. Appropriate improvement action is determined by analyzing and interpreting data over time, utilizing principles of variation. Process owners are responsible for continuously standardizing and simplifying processes to increase reliability through the reduction of variation and waste. They are also responsible for proactively recognizing and implementing proven or evidence-based practices for existing processes, using current literature sources and benchmarking activities internally as well as externally.
 - F. If processes are unstable, process owners investigate and work to remove the cause of the variation. If the variation results in a significant event, they are analyzed and acted on according to policy.
 - G. When data indicates a need to identify and correct the root cause of a problem, or there is an opportunity to move to a new level of performance, improvement projects are

established. In these cases, teams, formal and informal, apply improvement processes that systematically move through the following five steps:

1. Define the project
2. Measure current performance
3. Analyze to identify causes
4. Improve
5. Control

- H. To assure that the changes required for improvement are successful, the human aspects of change are also addressed using a change model that addresses the need for effective change leadership, creating a shared need, shaping a shared vision, mobilizing commitment, implementing the change monitoring results, and anchoring the change in systems and structure.
- I. Communication of improvement opportunities, new processes or practices are reported up and down the organization through defined reporting structures which include department, Facility and system-wide councils.
- J. When current processes are not able to achieve customer expectations and/or established performance goals, new processes and services are designed and implemented utilizing evidence-based and innovative practices. A systematic approach involves multiple departments and disciplines working collaboratively, using information from patients, staff, payers, and others, along with current comparative information/data from other organizations.
- K. Data for monitoring the effectiveness and safety of services and the quality of care at each Facility, including clinical outcomes, patient safety, evidence-based practice, utilization management and patient satisfaction, are collected and evaluated on an ongoing basis and reported up to governance for recommendations and actions on at least a quarterly basis.
- L. When performance issues may be related to the professional practice of an individual medical staff member, medical staff committees review such professional practices and determine appropriate action, if any.
- M. All proceedings, records, and materials related to Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management and peer review activities are confidential in accordance with federal and state laws. Meetings will be held in confidence and minutes will be maintained separately. Dedicated portals with restricted access will be created to allow the sharing of confidential information.
- N. When performance issues may be related to the performance of a staff member, they will be handled through the appropriate Banner Health Human Resources policies and/or procedures.
- O. New committees and new organization structures may be formed from time to time and the work performed by these groups is intended to be covered under the auspices of the Quality Plan and the protections afforded by federal and state law.

IV. Procedure/Interventions:

- A. N/A

V. Procedural Documentation:

- A. N/A

VI. Additional Information:

- A. N/A

VII. References:

- A. Arizona Statutes: A.R.S. § 36-441 et seq. A.R.S. § 36-2401 et seq., A.R.S. § 36-445 et seq.
- B. California Statutes: Cal.Health & Safety Code § 101848.9D.
- C. Colorado Statutes: C.R.S.A. § 25-3-109
- D. Nebraska Statutes: Title 172 NAC, Chapter 5
- E. Nevada Statutes: NRS 439.865
- F. Wyoming Statutes: W.S. 35-2-910
- G. CMS Conditions of Participation
- H. The Joint Commission

VIII. Other Related Policies/Procedures:

- A. Banner Health Strategic Initiatives/Plan
- B. Facility Work Plans
- C. [Event Reporting](#) (#911)
- D. [Patient Complaint and Grievance](#) (#1341)
- E. [Peer Review, Medical Staff](#) (#760)

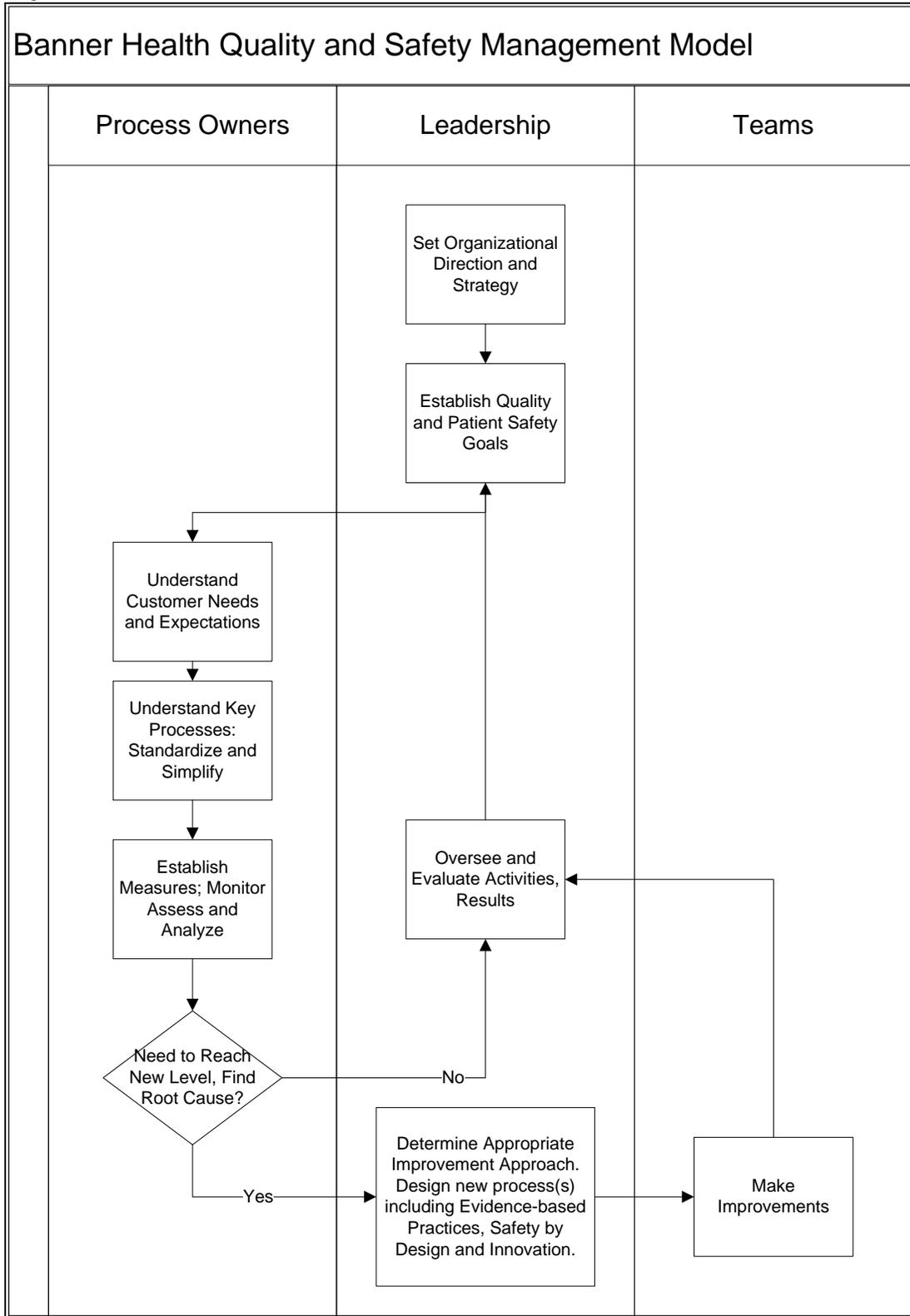
IX. Keywords and Keyword Phrases:

- A. Board
- B. Care Management
- C. Mission
- D. Quality Management
- E. Quality Plan
- F. Vision
- G. Safety Plan
- H. Patient Safety Plan

X. Appendix:

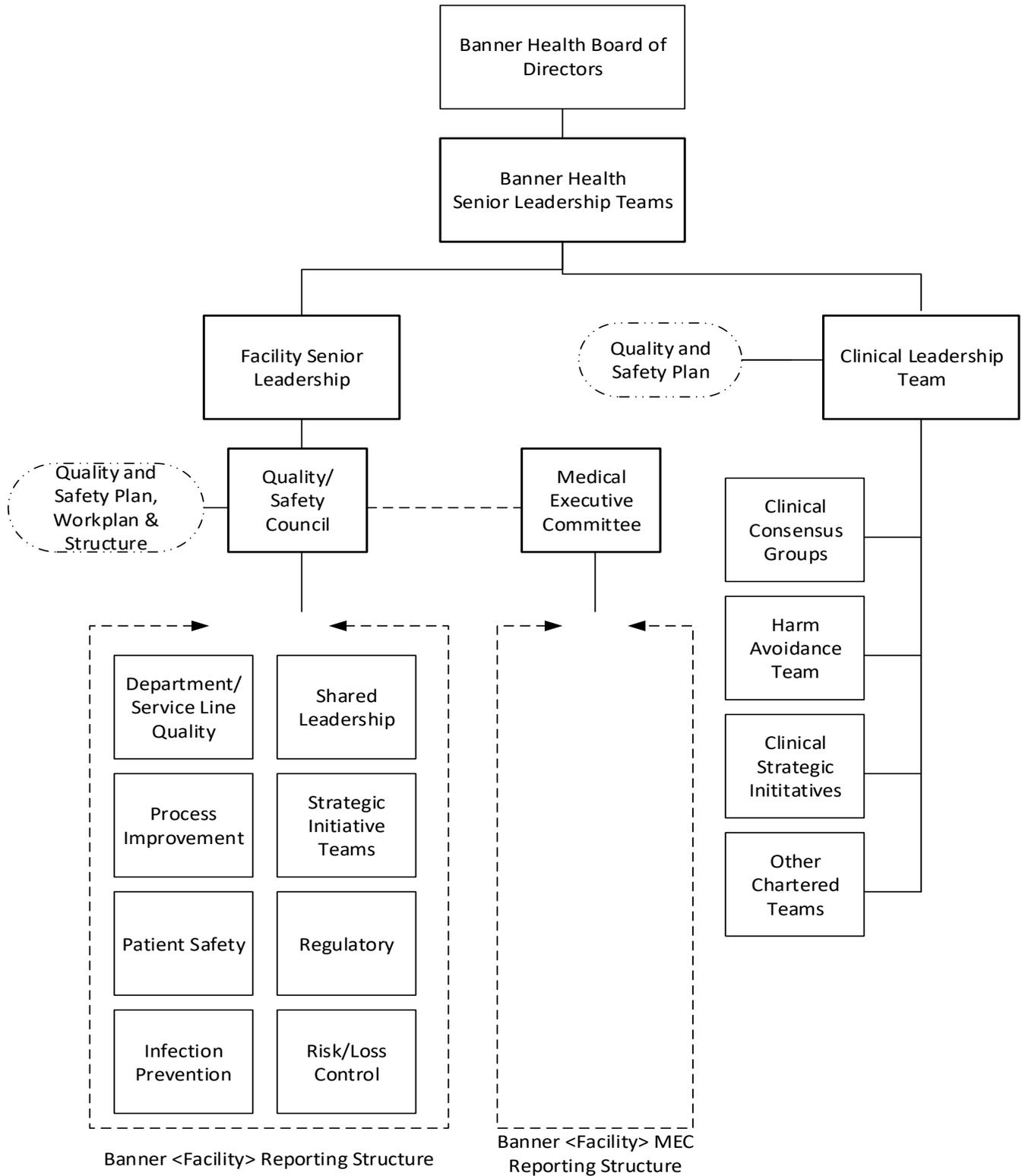
- A. Figure 1: Banner Quality and Safety Management Model (See Section III.A: Appendix below)
- B. Figure 2: Banner Facility Quality and Safety Structure Template (See Section III.B.2: Appendix below)

(Figure 1)



(Figure 2)

Banner Health <Facility> Quality and Safety Structure Template



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 	ORG.2404 Performance Improvement and Patient Safety Plan
Last Reviewed: (04/2007); 04/2014; 01/2015; 02/2016; 02/2017; 01/2018; 01/2019	Replaces Policy Dated: 04/2007; 04/2014; 01/2015; 02/2016; 02/2017
HCA Effective Date: N/A	Approved by BOT: 04/2014; 01/2015; 08/2016; 03/2017; 02/2019
Submitted by: Risk Management	Page 1 of 14

PURPOSE

Sunrise Hospital and Medical Center and Sunrise Children’s Hospital (SHMC|SCH) develops, implements, and maintains an effective, ongoing, facility-wide, data-driven quality and patient safety assessment, and performance improvement program.

SCOPE

Housewide

POLICY/STRUCTURE

- A. SHMC|SCH has a leadership structure to support operations and the provision of care.
- B. Structure is formed by three (3) leadership groups:
 - 1. Board of Trustees (BOT), the organized medical staff which is represented by the Medical Executive Committee (MEC), and Senior Leadership.

BOT

- A. BOT serves as the governing body legally responsible for the conduct of SHMC|SCH as an institution.
- B. BOT has ultimate responsibility for safety and quality which is derived from their legal responsibility and operational authority for SHMC|SCH performance.
- C. In this context, the BOT provides for internal structures and resources, including staff that supports safety and quality.
- D. Working with the MEC and Senior Leaders, the BOT establishes a mission, vision, and goals of the organization to support safety, quality of care, treatment, and services.
- E. Roles and responsibilities of the BOT in ensuring performance improvement (PI) and patient safety activities include:
 - 1. Reflects the complexity of SHMC|SCH organization and services; involves all SHMC|SCH departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.
 - 2. Identifies those responsible for planning, management, and operational activities.
 - 3. Identifies those responsible for the provision of care, treatment, and services.
 - 4. Defines in writing its responsibilities.
 - 5. Approves SHMC|SCH written scope of services.
 - 6. Selects and approves the Chief Executive Officer (CEO) responsible for managing SHMC|SCH.
 - 7. Works with the Senior Leaders and the MEC to annually evaluate SHMC|SCH performance in relation to its mission, vision, and goals.
 - 8. Ensures the ongoing program for quality improvement and patient safety is defined, implemented, and maintained.
 - 9. Establishes clear expectations for safety.

10. Provides the organized medical staff, represented by the MEC with the opportunity to participate in governance and the opportunity to be represented at BOT meetings.
11. Assumes full legal authority and responsibility for operations of SHMC|SCH and medical staff.
13. Establishes a process for making decisions when a leadership group fails to fulfill its responsibilities and/or accountabilities.
14. Provides for the resources needed to maintain safe, quality care, treatment, and services.
15. Provides a system for resolving conflict among individuals working within the organization.
16. Receives and reviews reports summarizing the data, analysis, findings, and recommendations related to facility-wide organizational PI Projects and Clinical Safety Improvement Program (CSIP).
17. Reviews the annual PI and CSIP Appraisal.
18. Approves the annual PI and Patient Safety Plan.

Medical Staff and MEC

- A. SHMC|SCH has an organized medical staff that is accountable to the BOT.
- B. Medical staff is represented by the MEC.
- C. Role and responsibilities of the MEC in ensuring PI and patient safety activities include:
 1. Organized and accountable to the BOT for the quality and safety of the medical care provided to the patients.
 2. Operates under Medical Staff Bylaws and Rules and Regulations approved by the BOT.
 3. Oversees the quality of care, treatment and services provided by those individuals with clinical privileges.
 4. Approves the PI and Patient Safety Plan (PSP) including the design of the PI and patient safety activities.
 5. Requires the Medical Staff departments to continuously assess and improve the quality of care and services provided, continue to evaluate the competence of individuals with or without clinical privileges (i.e., allied health providers) and provide information for the re-credentialing process.
 6. Requires the Medical Staff to maintain quality control programs, as appropriate.
 7. Systematically evaluates SHMC|SCH performance activities of departments, committees and functional teams by the review of minutes, reports, and inquiries directed to/from the departments or committees by the MEC.

Senior Leaders

- A. SHMC|SCH identifies the responsibilities of its Senior Leaders.
- B. Role and responsibilities of Senior Leaders in ensuring PI and patient safety activities include:
 1. CEO manages SHMC|SCH and leads the Senior Leadership group.
 2. Senior Leaders work with the organized medical staff and the governing body to define their shared and unique responsibilities and accountabilities.
 3. CEO, MEC, the Chief Nurse Officer (CNO), and the Vice-President (VP) of Quality Management (QM) work together to make certain that the facility-wide PI and CSIP along with training programs address identified problems.
 4. Discuss issues that affect SHMC|SCH and the population(s) it serves, including the following:
 - a. PI and Clinical Safety Improvement activities.

- b. Reported safety and quality issues.
 - c. Proposed solutions and their impact on SHMC|SCH resources.
 - d. Reports on key quality measures and safety indicators.
 - e. Safety and quality issues specific to the population served.
 - f. Input from the population(s) served.
5. Ensures the scope of the safety program includes the full range of safety issues, from potential to no-harm errors (e.g., near misses).
 6. Provides and encourages the use of systems for blame-free internal reporting of a system or process failure.
 7. Defines sentinel events and ensures the performance of credible serious event analysis in response to sentinel events.
See: [SUNR.PSO.003 Patient Safety Serious Event Analysis Policy](#)
 8. Selects one (1) high-risk process and conducts a proactive risk assessment at least every 18 months.
- C. Creates and maintains a culture of safety and quality throughout the organization.
- D. Organization regularly evaluates the internal culture of safety and quality using the Agency for Healthcare Research & Quality (AHRQ) Hospital Survey on Patient Safety Culture.
- E. Survey allows Leaders to:
1. Prioritize and implement changes identified by the survey.
 2. Provide opportunities for all individuals who work in SHMC|SCH to participate in safety and quality initiatives.
 3. Develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
 4. Create and implement a process for managing behaviors that undermine a culture of safety.
 5. Provide education that focuses on safety and quality for all individuals.

Patient Safety Officer (Nevada Revised Statutes [NRS] 439.870)

- A. Organization has designated the Risk Manager as the Patient Safety Officer for the organization.
- B. Patient Safety Officer:
 1. Serves on the Quality Care and Patient Safety Committees (PSC).
 2. Promotes a culture of safety and the elimination of avoidable harm.
 3. Supervises the reporting of all sentinel events.
See: [SUNR.PSO.003 Patient Safety Serious Event Analysis Policy](#)
 4. Reports all sentinel events and the actions taken to ensure the event does not reoccur.
 5. Takes action as deemed to be necessary to ensure the safety of patients as a result of an investigation of the event.

Department Directors

- A. Department Directors of each ancillary/nursing service area is responsible for all PI and Patient Safety activities as they relate to their specific areas.
- B. Directors are responsible for the continuous assessment and improvement of their department's performance, promotion of patient safety, and the maintenance of appropriate quality control programs.
- C. Directors are responsible for evaluating the effectiveness of care delivered in their departments and the clinical performance of their staff.
- D. Although it is recognized that process issues or deficiencies account for most variances in performance, when PI activities lead to a determination that an individual is unable or

unwilling to improve, modification of the individual's job assignment will occur or other appropriate action will be taken.

- E. Significant findings of PI or Patient Safety activities will be reported through the appropriate channels.

PSC and Quality Care Committee (QCC)

- A. PSC and the QCC are responsible to the BOT, MEC, and Senior Leaders for the overall operation of the PI and PSP.
- B. These interdisciplinary committees include but are not limited to, representatives from the BOT, Senior Leaders, Medical Staff, QM, Pharmacy, Nursing Leadership, Infection Control, Ancillary Services Directors, Patient Safety Officer, and Facility Safety Officer.
- C. On an annual basis the PSC and QCC performs an annual PI appraisal of the PI activities.
- D. At this meeting, current PI priorities, patient safety priorities, and associated activities are reviewed and evaluated.
- E. General functions of the PSC and QCC include:
1. Collects data to monitor its performance.
 2. The BOT, MEC, and Senior Leaders set priorities for and determine the frequency of data collection.
 3. Measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, SHMC|SCH services, and operations.
- F. Collects data and reports to the MEC, and BOT.
- G. Types of data collected includes but is not limited to:
1. Operative or other procedures that place patients at risk of disability or death.
 2. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.
 3. Adverse events related to using moderate or deep sedation or anesthesia.
 4. Use of blood and blood components.
 5. All reported and confirmed transfusion reactions.
 6. Results of resuscitation.
 7. Behavior management and treatment.
 8. Significant medication errors.
 9. Significant adverse drug reactions.
- H. SHMC|SCH considers collecting data on the following:
1. Staff opinions and needs
 2. Staff perceptions of risk to individuals
 3. Staff suggestions for improving patient safety
 4. Staff willingness to report adverse events
- I. Patient perception of the safety and quality of care, treatment, and services.
- J. Evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.
- K. Effectiveness of its response to change or deterioration in a patient's condition.
1. Note: Measures may include length of stay, response time for responding to changes in vital signs, cardiopulmonary arrest, respiratory arrest, and mortality rates before and after implementation of an early intervention plan.
- L. PSC shall have oversight of the SHMC|SCH Patient Safety Program, which includes but is not limited to:
1. Review the annual PSP and Strategies.
 2. Collect data to monitor PSP performance.
 - a. Measure, analyze, and track safety indicators, including adverse patient

- events, and other aspects of performance that assess processes of care, SHMC|SCH services, and operations.
3. Types of data collected includes but is not limited to:
 - a. Patient safety related to the use of at least two (2) patient identifiers when giving medication, blood products, or before a procedure.
 - b. Infection Prevention as it relates to the use of proven guidelines such as hand cleaning to prevent infections of Catheter Associated Urinary Tract Infections (CAUTI), Central Line Associated Bloodstream Infections (CLABSI), Surgical Site Infections (SSI), and other SHMC|SCH acquired infections.
 - c. Safe surgical practices by prevention of mistakes made in surgery such as wrong patient, wrong site, and wrong procedure with use of standardized *Time Out* practices before any treatments or procedures.
 - d. Use of medication safety as it relates to the prevention of significant medication errors.
 - e. Evaluate the effectiveness of all fall reduction activities including assessment, interventions, and education.
 - f. Evaluate the effectiveness of the reduction of all SHMC|SCH acquired conditions (HAC) to improve health outcomes and reduce length of stay.
 4. Receive reports from the patient safety officer pursuant to NRS. 439.870
 5. Review and evaluate the quality of measures carried out by the medical facility to reduce the number of severity of sentinel events and infections that occur at the medical facility.
 6. Ensures all Patient Safety policies/checklists follow protocols to improve the health outcomes of patients at the medical facility and will include, without limitation:
 - a. Checklists related to specific types of treatment must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
 - b. Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
 7. Checklists to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - a. Proper instructions concerning prescription medications;
 - b. Instructions concerning aftercare; and
 - c. Any other instructions concerning his or her care upon discharge.
 - M. Ensure that a policy for appropriately identifying a patient before providing treatment the policy will require the patient to be identified with at least two (2) personal identifiers before each interaction with a provider of healthcare.
 1. The personal identifiers may include without limitation, the name, and date of birth of the patient.
 - N. Ensure that a policy regarding the nationally recognized standard precautionary protocols to be observed by providers of health care at the facility including, without limitation, protocols relating to hand hygiene.
 - O. Monitor and document the effectiveness of the patient identification (ID) policy.
 - P. At least annually, review and revise the patient safety checklists and patient safety

- policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
- Q. Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
- R. Ensure that on or before July 1 of each year, the Patient Safety officer will submit a report to the Director of Legislation Counsel Bureau for transmittal to the Legislative Committee on Health Care.
1. The report must include information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph (II).
- S. Evaluate the recommendations provided to the executive or governing body of the medical facility regarding:
1. The number of sentinel events that occurred at the medical facility during the preceding calendar quarter;
 2. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
 3. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- T. Evaluate the role of the Patient Safety Officer in the adoption of patient safety checklists and patient safety policies as required by NRS 439.877, including the review of the checklist and policies annually and revision of the checklists and policies as the patient safety committee determines necessary.
- U. QCC compiles and analyzes data
- V. Program includes, but is not limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and patient safety, including:
1. Sets expectations for using data and information to improve the safety and quality of care, treatment, and services.
 2. Responsible for the implementation of successful corrective action plans in affected problem areas.
 3. Measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, SHMC|SCH service and operations.
 4. Develops, implements, and maintains an effective, ongoing, facility-wide, data-driven quality assessment and performance improvement program.
 5. Compiles data in usable formats.
 6. Uses statistical tools and techniques to analyze and display data.
 7. Analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.
 8. Compares data with external sources, when available.
 9. Analyzes its Organ Procurement conversion rate data as provided by the Organ Procurement Organization (OPO).
 10. Uses the results of data analysis to identify improvement opportunities.
- W. In regard to staffing:
1. When SHMC|SCH identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of

- staffing, including nurse staffing, in its analysis of possible causes.
2. When analysis reveals a problem with the adequacy of staffing, the Senior Leaders responsible for the facility-wide patient safety program are informed, of the results of this analysis and actions are taken to resolve the identified problem(s).
 3. At least once a year, the leaders responsible for the facility-wide patient safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.
- X. QCC considers participation in Quality Improvement Organization (QIO) cooperative projects.
- Y. Trauma Program manages an intensive Performance Improvement and Patient Safety (PIPS) program regarding its practice.
1. Minutes of the program's reviews are submitted to the MEC and the BOT through the Department of Surgery.
 2. In addition, members of the SHMC|SCH Quality Assurance Program attend the Trauma Peer Review Committee meetings.
- Z. PSC and QCC ensures the organization improves performance on an ongoing basis, including:
1. Prioritizes the identified improvement.
 2. Takes action on improvement priorities.
 3. Evaluates actions to confirm that they resulted in improvements.
 4. Takes action when it does not achieve or sustain planned improvements.
- AA. PSC and QCC drafts priorities for the organization's PI activities, which are recommended for adoption through the MEC and the BOT.
- BB. QCC considers factors such as:
1. Focus on high-risk, high-volume, or problem-prone areas,
 2. Consider the incidence, prevalence, and severity of problems in those areas.
 3. Affect health outcomes, patient safety, and quality of care.

Patient Safety Organization (PSO)

- A. SHMC|SCH is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided.
- B. To further this objective, SHMC|SCH contracted with Hospital Corporation of America (HCA) PSO, LLC (HCA|PSO|LLC), a federally certified PSO, to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.
- C. Generally speaking, patient safety work product (PSWP) is not subject to subpoena or discovery in State or Federal court, in administrative proceedings, or pursuant to the Freedom of Information Act (FOIA), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act (PSQIA) and its associated regulations. *(See 42 Code of Federal Regulations [CFR] § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.)*
- D. SHMC|SCH will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses (RCA), patient safety communications, quality reviews, and other documents aimed at improving patient safety.
- E. Documents will be submitted in a standardized format to allow for comparison with like Providers.
- F. As part of this effort, SHMC|SCH will operate a Patient Safety Evaluation System (PSES) designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC.

- G. PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes.
- H. Designated SHMC|SCH personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

Methodology

- A. FOCUS-Plan-Do-Check-Act (PDCA) is the methodology used for PI projects.
- B. Using this methodology data is systematically aggregated and analyzed on an ongoing basis.
- C. Statistical tools used are displayed in diagram II below.

FOCUS

Find an Improvement Opportunity:

- A. Review results of measurement activities and input from staff, patients, medical staff, and other customers.
- B. How are we doing compared to ourselves/external benchmarks over time?
- C. What situation yields an opportunity for improvement?
- D. What processes should be addressed first?

Organize a Team that Knows the Process:

- A. Is there representation from those who work in the process
- B. Educate the team on the PI process.
- C. Establish the team purpose, process and measures of team progress.

Clarify Current Knowledge of the Process:

- A. Is the process well defined, including the customers, their needs and expectations?
- B. Do our perceptions of the process relate to the actual process?
- C. “Flow chart” the process to determine the actual flow or sequence of events that the process follows.
- D. What is the baseline data on the current process?
- E. Review recent scientific literature for up to date information regarding the process.

Uncover Root Cause of the Process Variation:

- A. “Fishbone” a cause and effect diagram to allow the team to identify, explore and graphically display, in increasing detail, all of the possible causes related to a problem.
- B. Are the causes the root cause or just symptoms of the problem?
- C. What are the causes that have the greatest impact in priority order?

Start the Improvement Cycle:

- A. What new knowledge have you acquired about the process?
- B. What changes need to be made to improve the process?

PDCA

Plan Improvement

- A. Who, what, when and how are we going to change the process
- B. Data collection-who, what, where, when and how are we going to track the process change?
- C. Identify those forces that assist or prevent change-force field analysis.

Do Improvement:

- A. Implement change

Check Results:

- A. Do results match the expectations?
- B. What was learned?
- C. What does the team want to continue to do?

- D. What would the team do differently?

Act

(To sustain improvement and continue to improve or abandon change and start cycle again)

- A. What part of the process needs to be standardized?
B. What policies/procedures need to be revised?
C. Who needs to be trained?
D. Determine method for ongoing measurement.

Serious Event Analysis

- A. Is the primary PI methodology used for analysis of significant unanticipated outcomes and/or Sentinel Events.

See: [SUNR.PSO.003 Patient Safety Serious Event Analysis Policy](#)

EXTERNAL DATA SOURCES

- A. Data is also collected as indicated for participation in the following external databases or for participation with the following organizations:

Lavanta

- A. Centers for Medicare & Medicaid (CMS) contracted Quality Improvement Organization (QIO) has developed Healthcare QI Initiatives that examine patterns of practice.
B. Areas for study are suggested by practitioners in the community, university, hospital settings, nationally recognized patient safety and quality improvement organizations and CMS.
C. Studies enable hospitals and medical staff to compare their performance with what may be optimal levels of practice.

Comprehensive Health Outcomes Information System (CHOIS) Reports

- A. CHOIS is designed to identify opportunities for improvement, identify best practices, and manage resources appropriately, effectively, and efficiently.
B. Clinical Outcome Summary Reports are distributed on a quarterly basis.
C. Data captured in this report reflects numerous clinical indicators.
D. These indicators were developed through medical staff focus groups.
E. Data is risk and severity adjusted using CMS's Refined diagnosis-related group (DRG)s and economic cycle research institute (ECRI), a risk index used to adjust complication rates, Risk Adjusted Mortality Index (RAMI) and the Risk Adjustment Specialty Algorithm (RASPEC) as appropriate.
F. Each hospital is provided with actual and risk adjusted mortality and complication rates.
G. Rates are compared to the company overall and national statistics.
H. Patient and Provider level details are provided to facilitate a detailed analysis of the cases reflected in the data.

The Joint Commission (TJC) Measurement System (ORYX)

- A. This is TJC initiative to integrate performance measures into the accreditation process.
B. It involves a collection of service, process and outcome indicators related to specific patient populations.
C. Data for this initiative is collected through the Comprehensive Outcomes Measurement Evaluation and Transmission (COMET) database.
D. Information is collected at the facility level and transmitted directly to TJC from HCA, as the chosen vendor for this project.
E. Data abstracted through the COMET system are also submitted to CMS for public reporting through the Hospital Compare website.
F. Hospital Compare website was created through the efforts of the CMS, an agency of the United States Department of Health and Human Services (DHHS), along with the

- Hospital Quality Alliance (HQA).
- G. HQA is a public-private collaboration established to promote reporting on hospital quality of care.
 - H. HQA consists of organizations that represent consumers, hospitals, Providers and nurses, employers, accrediting organizations, and Federal agencies.
 - I. Information on this website can be used by any adult needing hospital care.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

- A. HCAHPS is a national, standardized, publicly reported survey of patients' perspectives of hospital care.

Vermont Oxford Neonatal Database

- A. Oxford Neonatal Database is a comprehensive database of 600 plus neonatal intensive care (NICU) centers which compares morbidity, mortality, and length of stay data on the very low birth weight infants (501 to 1500 grams).
- B. As part of this network, the neonatal intensive care quality benchmarking project applies a team approach to health care benchmarking with the goal of improving the effectiveness and efficiency of neonatal intensive care.

Cancer Registry

- A. Cancer Registry submits cancer data on select neoplasms to the State of Nevada Administrative Code (NAC) 457.010 to 457.040.
- B. Data is generally requested annually.
- C. Cancer Registry department manages the cancer program and the American College of Surgeon's Commission on Cancer accreditation.
- D. Accreditation program maintains a robust set of metrics pertaining to 37 standards for the diagnosis, treatment and follow-up of cancers.
- E. As part of the accreditation, the Cancer Registry collects data adhering to the Commission of Cancer (COC)s strict criteria and submits data to the National Cancer Data Base (NCDB).
- F. Data is submitted to the NCDB at schedule intervals.
- G. NCDB data is used nationally to identify areas for quality improvement as well as direct other important activities.
- H. NCDB database is available at a facility level providing tools such as hospital comparison benchmarks, survival reports, Cancer Program Practice Profile Reports, Rapid Quality Reporting System, and the Cancer QI Program data reports.
- I. COC used NCDB data to direct participating organizations to perform special studies throughout the year.

Trauma Registry

- A. Trauma Registry at Sunrise is a State of Nevada database.
- B. Nevada Trauma Registry (NTR) data is collected from all licensed acute care hospitals and trauma centers in Nevada.
- C. NTR can provide information on the incidence, and prevalence, morbidity, and mortality of injuries in Nevada.
- D. Data can be broken down to a specific county, specific hospital, specific race, or specific age group, for example.
- E. Data are available for state, private or federal entities, grant applicants to measure the impact of trauma on Nevada and initiate health education programs that address traumatic injuries.

Society of Thoracic Surgeons (STS)

- A. Offers outcome programs in the areas of Adult Cardiac, General Thoracic, and Congenital surgery.

- B. By committing to collecting outcomes data to the STS National Database, surgeons are committing to improving the quality of care that their cardiothoracic surgery patients receive.
- C. SHMC|SCH participates in the STS database, using the national comparisons and benchmarking as an integral part of the PI program for Cardiovascular Services.

American College of Cardiology (ACC)/National Cardiovascular Data Registry (NCDR)

- A. NCDR is the recognized resource for measuring and quantifying outcomes and identifying gaps in the delivery of quality cardiovascular patient care in the United States.
- B. Its mission is to improve the quality of cardiovascular patient care by providing information, knowledge and tools, implementing quality initiatives, and supporting research that improves patient care and outcomes.

Perinatal Services Quality Initiative

- A. Perinatal Services Program is an HCA Corporate Initiative to improve perinatal services and reduce the risk associated with the delivery of maternal and infant care.

Emergency Management Risk Initiative

- A. Emergency Management Risk Initiative audit is one of the fundamental elements in the creation of the risk managed Emergency Department (ED).
- B. This is the most powerful audit tool available in emergency medicine.
- C. It is clinically oriented and provides an unprecedented look at the individual practitioner, the emergency practitioners as a group, and ED systems.
- D. Audit is accomplished through the Sullivan Group via an agreement with HCA hospitals.
- E. SHMC|SCH participates on a semi-annual basis.

Get with the Guidelines GWTG™

- A. Stroke Management Tool (Outcome Sciences) is a comprehensive quality management measurement tool that captures critical information regarding the care and treatment of patients with an acute stroke, with an emphasis of secondary prevention.
- B. Database is used to assess and measure internal compliance of treatment standards, and the ability to provide concurrent comparison to external entities and provides national benchmarks.

ACTION Registry®-GWTG™

- A. ACTION Registry is a risk-adjusted, outcomes-based quality improvement program that focuses exclusively on high-risk ST Elevation Myocardial Infarction (STEMI)/non-ST (NSTEMI) patients.
- B. It helps hospitals apply American College of Cardiology (ACC)/American Heart Association (AHA) clinical guideline recommendations in their facilities and provides invaluable tools to measure care and achieve quality improvement goals.

Leapfrog

- A. Leapfrog Hospital Survey is the public reporting initiative launched in 2001 by the Leapfrog Group.
- B. Leapfrog Group is an independent, not-for-profit organization aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded.
- C. Leapfrog strives to make giant "leaps" forward in safety, quality, and affordability of healthcare by promoting transparency.
- D. Leapfrog Group Survey assesses hospital performance based on 28 different metrics.
- E. Leapfrog algorithm computes a letter grade reflecting the hospital's performance based on these metrics.
- F. Currently nine (9) different Safe Practices are assessed.

- G. These safe practices, created by the National Quality Forum (NQF), have been found to reduce preventable medical mistakes.
- H. Leapfrog works to continually assess safe practices and new practices are added or removed accordingly.
- I. Leapfrog algorithm also analyzes 18 data points from the publically reported data as required by the CMS.

National Healthcare Safety Network (NHSN) Database

- A. NHSN is a secure, internet-based surveillance system that integrates former Center for Disease Control (CDC) surveillance systems, including the National Nosocomial Infections Surveillance System (NNIS), National Surveillance System for Healthcare Workers (NaSH), and the Dialysis Surveillance Network (DSN).
- B. NHSN enables healthcare facilities to collect and use data about HAC infections, adherence to clinical practices known to prevent HAC infections, the incidence or prevalence of multidrug-resistant organisms within their organizations, trends and coverage of healthcare personnel safety and vaccination, and adverse events related to the transfusion of blood and blood products.

REFERENCES

§482.21 Condition of Participation: Quality Assessment and Performance Improvement Program
NAC 449.3152 Quality Improvement Program
NRS 439.865 Patient Safety Plan
NRS 439.870 Patient Safety Officer
NRS 439.875 Patient Safety Committee
Joint Commission Requirements for Performance - Performance Improvement Chapter

PERFORMANCE IMPROVEMENT REPORTING STRUCTURE

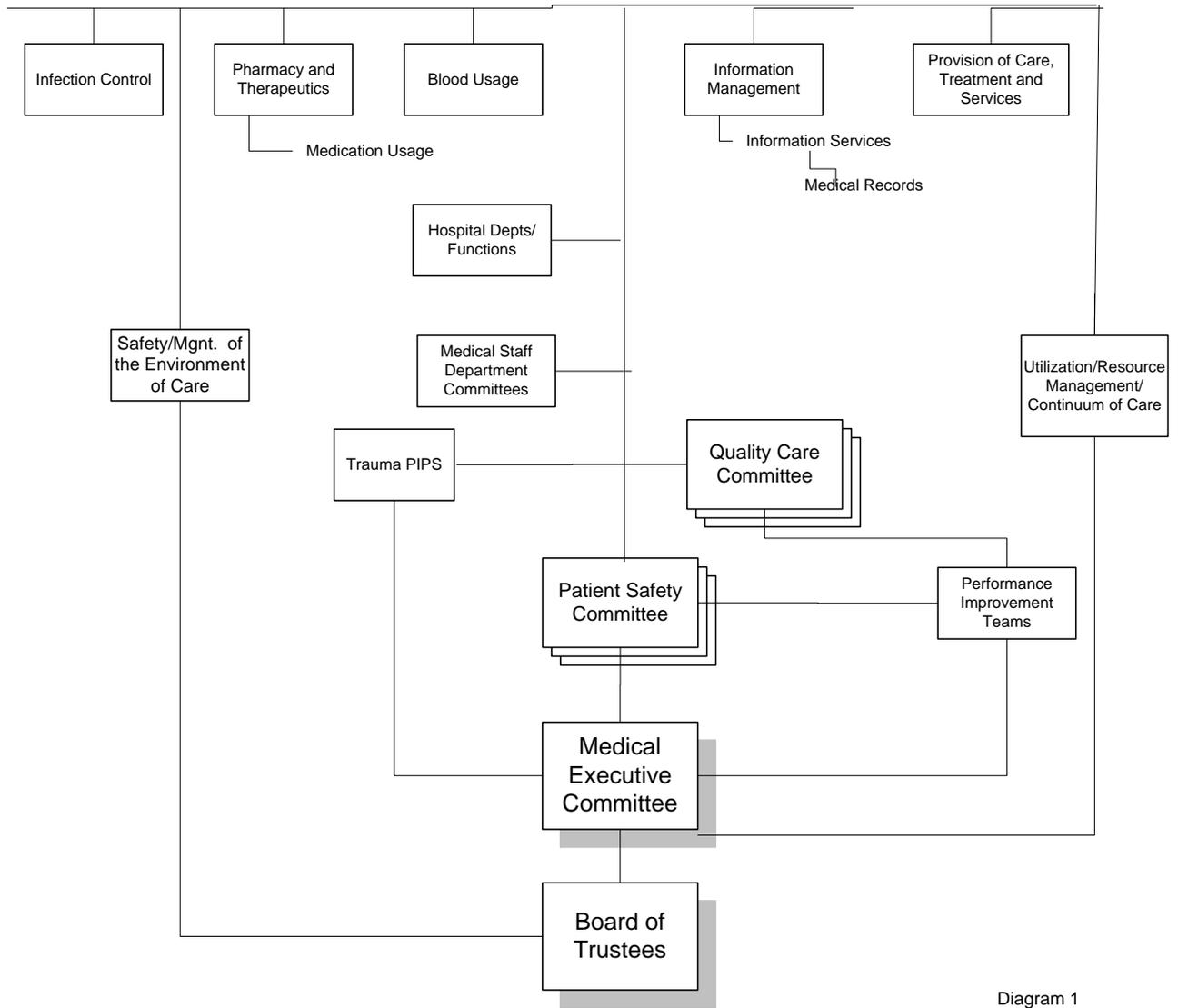
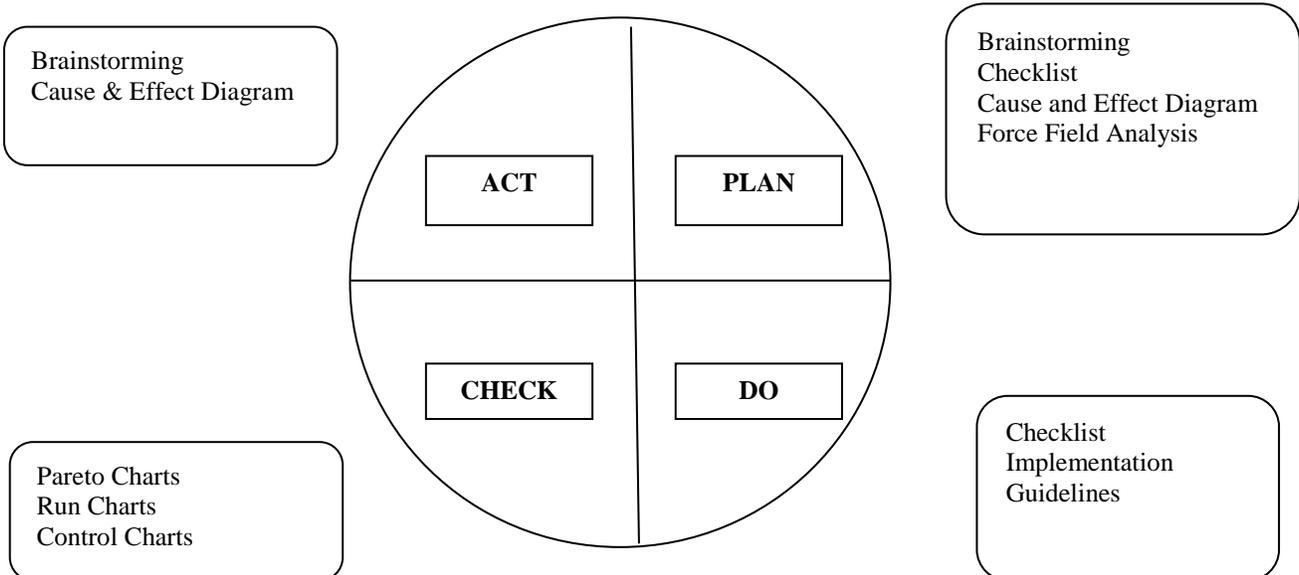
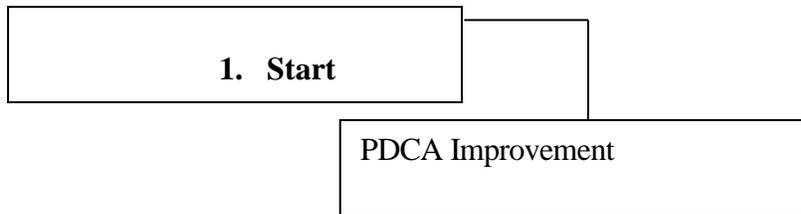
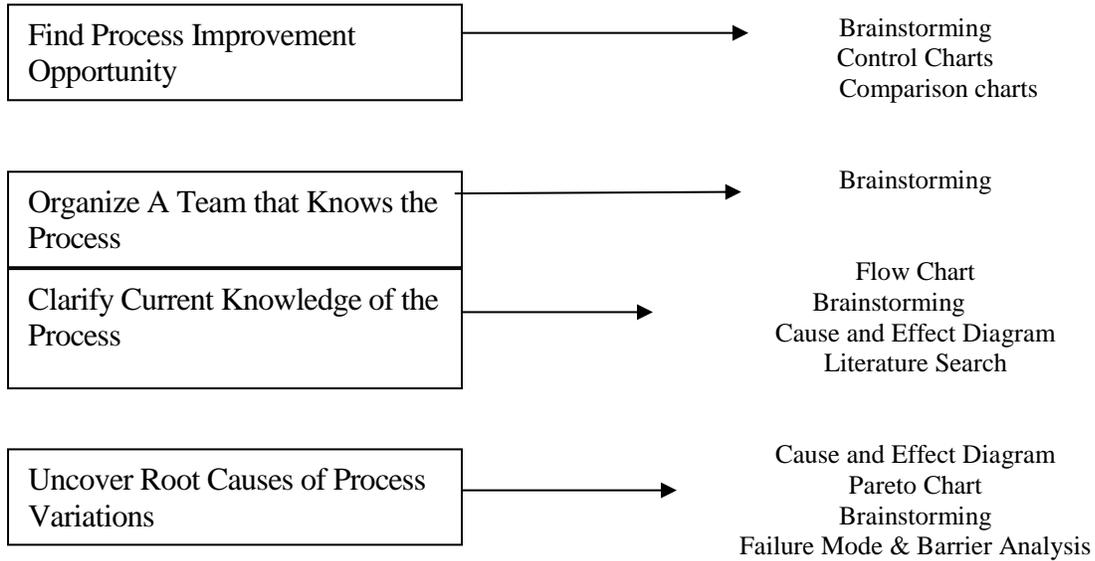


Diagram 1

FOCUS - PDCA



MOUNTAINVIEW HOSPITAL



PATIENT SAFETY PLAN

CY 2019

CY 2019 Patient Safety Program TABLE OF CONTENTS

I.	Introduction	2-5
-	<i>Purpose, Scope and Responsibility</i>	
-	<i>Participation in PSO</i>	
-	<i>Definition of Terms</i>	
II.	Policy	5-6
III.	Culture of Safety	6
IV.	Structure, Roles and Responsibilities	6-9
V.	Mechanisms for Coordination	9-10
-	<i>Patient Safety Committee (PSC)</i>	
VI.	Communicating with Patients About Safety	10
VII.	Education	10-11
VIII.	Safety Improvement Activities	11-12
-	<i>Prioritization of Patient Safety Activities</i>	
-	<i>Routine safety-related data collection analysis</i>	
-	<i>Identification, reporting, and management of patient safety events</i>	
-	<i>Proactive Risk Identification and Reduction</i>	
-	<i>Assembly Bill 280 – Monitoring and Compliance</i>	
-	<i>Senate Bill 339 – Infection Control Program</i>	
IX.	Reporting Patient Safety Results	12-13
XI.	2019 PSC Goals	14
XII.	Annual Review	14
XIII.	References / Authority	14
APPENDICES		
1	Patient Safety Program (schematic)	15
2	2019 National Patient Safety Goals Overview	16-18
3	Infection Control Plan	19

CY 2019 Patient Safety Program

I. Introduction

Purpose, Scope and Responsibility

- ✓ Purpose:
 - To define the essential components of the Patient Safety Program at MountainView Hospital, which is committed to ensuring a safe environment and reliable care processes.
 - To cultivate a culture of patient safety through the ongoing promotion of a safe practices and personal accountability.
- ✓ Scope: Patient safety is everyone's responsibility. The MountainView Hospital Patient Safety Program covers all activities and functions relating to patient safety at all sites and services within the organization.
- ✓ Responsibility: Leaders, employees, members of the medical staff, students and volunteers are to be familiar with and involved in the Patient Safety Program.

Participation in Patient Safety Organization

- ✓ MountainView Hospital is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided to the Hospital. To further this objective, the Hospital contracted with HCA Patient Safety Organization, LLC ("HCA PSO, LLC"), a federally certified Patient Safety Organization ("PSO"), to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.
Generally speaking, patient safety work product ("PSWP") is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act ("FOIA"), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act ("PSQIA") and its associated regulations. (See 42 CFR § 3.204, *Privilege of patient safety work product*; and 42 CFR § 3.206, *Confidentiality of patient safety work product*.)
The Hospital will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses, patient safety communications, quality reviews, and other documents aimed at improving patient safety. Documents will be submitted in a standardized format to allow for comparison with like providers. As part of this effort, the Hospital will operate a Patient Safety Evaluation System ("PSES") designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC. The PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes. Designated Hospital personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

Definition of Terms

Accountability:

An obligation or willingness to accept responsibility for one's actions.

Adverse Event:

Event under the control of a provider which has caused harm and requires a new or modified

physician order for management of the patient's health care. See Policy RM19: Sentinel Event for specific event list and RM13: Disclosure of Adverse Events.

Hazardous condition:

Any set of circumstances (exclusive of the disease or condition in which the patient is being treated), which significantly increases the likelihood of serious adverse outcome.

Healthcare FMEA:

Healthcare Failure Mode and Effects Analysis: A proactive model for addressing potential risks within the organization.

Human Error:

An unintended act, or failure to act, that results in actual or potential patient injury, harm or adverse event in the process of care delivery.

Near miss:

Any process variation that did not affect the patient outcome, but for which a recurrence carries a significant chance of serious adverse outcome.

Non-punitive:

No punishment or disciplinary action imposed for specific error.

Patient injury:

Major permanent loss of function, sensory, motor, or intellectual impairment not present at admission, requiring continued treatment or lifestyle change. When "major permanent loss of function" cannot be immediately determined, patient injury is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

Patient safety event:

All adverse events or potential adverse events that are deemed preventable and Healthcare associated infections as defined by the CDC that are deemed to be preventable.

PSQIA

The Patient Safety and Quality Improvement Act (PSQIA) of 2005, Pub. L. 109-41, 42 U.S.C. 299b-21-b-26 (for which the final rule implementing the regulations became effective on January 19, 2009), was enacted in response to growing concern about patient safety in the United States and the Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System*. The goal of the Act is to improve patient safety by encouraging voluntary and confidential reporting of events that adversely affect patients.

PSO

A Patient Safety Organization (PSO) means a private or public entity or component thereof that is listed as a PSO by the Secretary of Health and Human Services. A health insurance issuer or a component organization of a health insurance issuer may not be a PSO. The PSO enters into bona fide contracts, each of a reasonable period of time, each with a different provider for the purpose of receiving and reviewing patient safety work product.

PSES

A Patient Safety Evaluation System (PSES) means the collection, management, or analysis of information for reporting to or by a PSO.

PSWP

Patient Safety Work Product (PSWP) (1) Except as provided in (2) below, patient safety work product means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material) (i) Which could improve patient safety, health care quality, or health care outcomes; and (A) Which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO, and such documentation includes the date the information entered the patient safety evaluation system; or (B) Are developed by a PSO for the conduct of patient safety activities; or (ii) Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system. (2)(i) Patient safety work product does not include a patient's medical record, billing and discharge information, or any other original patient or provider information; nor does it include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a PSO shall not by reason of its reporting be considered patient safety work product. (ii) Patient safety work product assembled or developed by a provider for reporting to a PSO may be removed from a patient safety evaluation system and no longer considered patient safety work product if: (A) The information has not yet been reported to a PSO; and (B) The provider documents the act and date of removal of such information from the patient safety evaluation system. (iii) Nothing in this part shall be construed to limit information that is not patient safety work product from being: (A) Discovered or admitted in a criminal, civil or administrative proceeding; (B) Reported to a Federal, State, local or Tribal

governmental agency for public health or health oversight purposes; or (C) Maintained as part of a provider's recordkeeping obligation under Federal, State, local or Tribal law.

Reliability:

The extent of consistent performance over time.

Sentinel Event:

A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, and/or severe temporary harm (TJC, 2016). (A permanent loss of function related to the natural course of the patient's illness or underlying condition is not a Sentinel Event.) The State of Nevada defines a sentinel event as an event included in Appendix A of "Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report," published by the National Quality Forum (Nevada Revised Statutes NRS §439.830 – effective October 1, 2013).

Sentinel Event Alert Gap Analysis:

A model for prioritizing and addressing potential risks related to publish external sentinel or warning alerts.

Unusual Occurrence:

Any event or condition not consistent with the normal or usual operation of the hospital or department and which has the potential for causing patient or visitor injury or property damage. (See policies – RM19: Sentinel Event and RM13: Disclosure of Adverse Events).

II. Policy

The Board of Trustees delegates responsibility for oversight of the patient safety program to the Patient Safety Committee. The Patient Safety Committee monitors and evaluates the effectiveness of the Patient Safety Program and generates feedback and actions as appropriate. The Patient Safety Committee prepares an annual report to the Quality Council, Medical Executive Committee (MEC), and the Board of Trustees (BOT). The report includes at a minimum, occurrence or trending of patient safety indicators and actions taken in response to actual occurrences as well as proactive assessments of high-risk activities. The Environment of Care Committee oversees non-clinical safety related processes and system issues that affect patients, employees, and visitors in the environment of care.

Risk Management maintains the hospital-wide occurrence reporting system for patients, employees, and visitor occurrences and a referral system for hospital staff and physicians to report potential claims. Risk Management in conjunction with Hospital Quality and Patient Safety Leaders investigate actual and potential safety risk within the organization. They also evaluate occurrences to identify those that may require immediate follow up actions or meet the Sentinel Event, the Safe Medical Device Act, or regulatory agency reporting criteria, including CMS, FDA, OSHA, State of Nevada DHHS, or Joint Commission. Notification is made to Administration, Risk Management, appropriate regulatory and accrediting agencies, equipment manufacturers and other appropriate individuals as necessary.

The Organization ensures timely coordination and dissemination of reporting and data management of patient safety information at the appropriate medical staff/organizational committees for review and discussion.

III. Culture of Safety

MountainView Hospital is committed to creating a culture of safety by designing or redesigning systems and processes geared to prevent, detect, and minimize the hazards and likelihood of error. MountainView Hospital is focused on prevention, not blaming individuals. Patient safety events are viewed as an opportunity to learn. The Hospital believes in balancing the organization’s accountability and the individual’s accountability for assuring safe practices and a safe environment to care for patients.

IV. Structure, Roles and Responsibilities

The philosophy guiding the promotion of a culture of patient safety is accountability. To achieve a culture of patient safety the following accountabilities are expected at MountainView Hospital:

<i>Role</i>	<i>Accountability</i>	<i>Specific Tasks</i>
Board of Trustees, with Senior Leadership	Set goals, monitor performance & require accountability.	<ul style="list-style-type: none"> • Receive regular and thorough reports on patient safety risks, hazards and progress towards performance improvement objectives from the MEC and Patient Safety Committee. • Receive regular and thorough briefings regarding the results of culture measurement and performance improvement initiatives • Require multi-cause analysis of errors that lead to injury. • Set performance improvement goals for safety improvement. • Hold hospital leaders accountable for achieving the integrated patient safety agenda. • Receive systematic and regular assessment of resource and budget allocations to key systems (patient safety systems, human resources, quality systems, technology) related to the patient safety agenda.

Role	Accountability	Specific Tasks
Administrative (CEO, COO, CNO, VP's, Directors, & Physician Leaders	Set the agenda for the rest of the team	<ul style="list-style-type: none"> • Ensure that an integrated patient safety program is implemented throughout the hospital. • Set performance improvement priorities and identify how the hospital adjusts priorities in response to unusual or urgent events. • Allocate adequate resources for measuring, assessing and improving the hospital's performance and improving patient safety. • Measure and assess the effectiveness of the performance improvement and safety improvement activities. • Monitor implementation for of corrective action of patient safety events. • Ensure remedial activities, identified through analysis of reported patient safety events, are implemented, effective, and do not cause unintended adverse consequences. • Develop a proactive approach to reducing errors. • Encourage an environment of openness & collaboration. • Support a dialogue about outcomes between patients and clinicians including systems to obtain direct feedback from patients regarding performance of the organization • Educate staff about safety. • Support staff and lead by example.
Patient Safety Officer / CMO/Chief of Staff	Lead patient safety initiatives with the medical staff and organizational staff	<ul style="list-style-type: none"> • Lead an integrated patient safety program. • Serve as the primary point of contact for questions about patient safety, and coordinate patient safety for education and deployment of system changes. • Execute performance improvement priorities and adjusts priorities in response to unusual or urgent events. • Assure effectiveness in measuring, assessing and improving the hospital's performance and improving patient safety. • Lead a proactive approach to reducing errors and make recommendation to reduce patient safety events. • Lead in an environment of openness & collaboration. • Assure dialogue about patient safety issues occurs effectively between patients and clinicians. • Report progress regularly, and educate about patient safety • Support staff and lead by example.

Role	Accountability	Specific Tasks
Patient Safety Coordinators	Day to day coordination and facilitation of safety initiatives	<ul style="list-style-type: none"> • Implement operational aspects of the patient safety program throughout the hospital. • Implement proactive patient safety management that assures immediate, appropriate response to unusual or urgent events. • Participate in measuring, assessing and improving the hospital's performance and improving patient safety. • Be accountable for patient safety initiatives and strengthening a culture of safety in day to day practice. • Support an environment of openness & collaboration. • Support a dialogue about patient safety issues between patients and clinicians. • Report progress regularly, and educate about patient safety. • Support staff and lead by example.
Pharmacists	Ensure safe medication usage	<ul style="list-style-type: none"> • Ensure that authoritative, up-to-date drug information is available in reference form in patient care areas and prescribers' offices. • Periodically examine all drug products stored in patient care areas and procedures on drug storage/distribution to patient care areas. • Minimize the need for nurses to calculate, manipulate, or mix medications. • Establish a pharmacy led interdisciplinary team to spearhead medication safety activities. • Provide leadership to develop safe medication delivery systems.
Clinicians & Medical Staff	Monitor, report, & learn.	<ul style="list-style-type: none"> • Medical staff and other employee job descriptions and competency evaluations incorporate accountability for safety. • Medical staff & employees participate in education on the importance of safety, surveillance, and expectations for reporting safety concerns, beginning with orientation. • Medical staff & employees evaluations include an individual's contributions to safety for the organization. • Medical staff & employees are positively acknowledged for disclosing errors, near-misses, and safety concerns. • Employees and physicians work collaboratively assuring responsibilities of the team to the patients are met, and noticing errors before they cause harm. • Participate in the facility reporting system for PS events, both actual and potential event.

Role	Accountability	Specific Tasks
Patients/visitors	Involved partners in prevention.	<ul style="list-style-type: none"> • Inform doctors and nurses about medications they take, including prescriptions, over-the-counter drugs and dietary supplements. • Ask for written information about possible side effects. • Inform the doctors and nurses about allergies & adverse reactions. • Ask a relative or friend to be an advocate. • Learn about their medical condition by asking their doctor, nurse, and other reliable sources. • Upon hospital discharge, ask doctors for an explanation of the treatment plan to be used at home. • Provide feedback regarding performance of the organization • Report safety concerns through the Patient Safety hotline and other venues available.

V. Mechanisms for Coordination

MountainView Hospital Patient Safety Committee

The MVH Patient Safety Committee (PSC) or equivalent is a multidisciplinary team involving department representatives that meets not less than monthly. The Patient Safety committee or equivalent committee, is comprised of various health care professionals including but not limited to physicians and residents, nurses, pharmacists and administrators, and is chartered to oversee the implementation of the Hospital's Patient Safety Program. The Patient Safety Officer coordinates the PSC. The CEO, CMO, and Chair of Quality Council appoint medical leadership for the PSC.

Structures that support the Patient Safety Committee or equivalent works in conjunction with other safety committees, including but not limited to:

- Medication Safety
- Quality Council
- Environment of Care
- Falls Committee
- Infection Prevention Committee

The PSC reviews and develops implementation strategies for the NPSG's. Strategies include assessing and developing a culture of patient safety, encouraging a non-punitive reporting environment, developing a best practice infrastructure to foster the design of safety into our systems, and monitoring of systems risks and improvements. The PSC networks with other committees as appropriate per topic to gain consensus (e.g. Quality Council, Infection Prevention, Pharmacy, other). Sentinel Event Alerts and other industry alerts are routed to the appropriate committee or teams to ensure evaluation of current care processes incorporate recommended changes.

The PSC reviews Sentinel Event Alerts, other industry alerts, compliance to The Joint Commission National Patient Safety Goals, State regulatory requirements, adverse events and potential adverse events that are deemed to be preventable, health care associated infections as defined by the CDC that are deemed to be preventable, and assures recommendations are integrated into processes. Additional resources such as national and local professional organizations/associations are monitored for changes in standards and potential risk events.

Regular summary reports of progress are reported to the designated Quality Council, Medical Executive Committee, and the Board of Trustees.

The PSC reviews and approves plans to address key organizational concerns, such as Falls, Restraint Reduction, Patient/Family Education, Patient Mobility, Blood and Blood Components, Medication Safety, Adverse Drug Reactions (ADR's), Pressure Ulcer Prevalence, Health Care Associated Infections and Environmental issues updates.

The PSC recommends and provides direction for training on key initiatives and educational strategies related to patient safety.

VI. Communicating with Patients about Safety

It is MountainView Hospital's philosophy that accountability for patient safety is imbedded in a collaborative relationship involving our Board of Trustees, administrative leadership, our medical staff, employees, patients and family.

Patient safety awareness information is posted in public areas throughout the hospital. This information contains basic strategies for patients to assist in assuring their safety. The admission and discharge patient information also contains information on the patient role in safety. Patient Guides are provided to in-patients upon admission, and includes strategies prevent untoward events such as falls, medication errors, and infections while in the hospital. Annually, Patient Safety Awareness Week activities are planned to educate and inform staff, patients and the community. The MountainView Hospital consumer web page also includes access to an electronic version of the Patient Guide. Information and additional resources are provided to assure patient involvement in their care.

Patients or their families may contact the hospital to report patient safety concerns as well as to the State of Nevada Department of Health and Human Services or to the Joint Commission. The hospital's website and other patient materials include information on how to report issues internally as well as to the Joint Commission.

Patients are randomly selected to participate in completing the Patient Experience Survey after discharge, which include questions related to the patient safety experience. These results are reported to the hospital.

VII. Education

1. Staff Education

- General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety
- Specific Patient Safety Program training at orientation and annually thereafter will include:
 - An overview of the Patient Safety Program
 - Staff's role and responsibilities in the Patient Safety Program
 - Event reporting, including the events requiring reporting and the process for reporting events.
 - Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care;
 - Examples of specific job-related aspects of patient safety.

2. Physician Education - An overview of the Patient Safety Program is provided to physicians at time of initial appointment and periodically thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism and Culture of Safety processes.

3. Organizational Learning: Patient safety is everyone's responsibility. Everyone has a responsibility to report. By reporting concerns, it enables the organization to learn and improve processes, procedures, and systems.
4. Lessons Learned summaries are developed to communicate lessons learned from near misses or actual events. These summaries are shared with the leadership and employees to promote organizational learning and improvement.

**VIII. Safety Improvement Activities
Prioritization of Patient Safety Activities**

Prioritization elements are defined in the annual performance improvement plan and apply to patient safety initiatives. The PSC annual goals are listed at the end of this plan and meet the prioritization elements.

Routine safety-related data collection analysis

- Unusual Occurrence reporting (see policies RM21 Facility Event and Close Call Reporting, RM13: Disclosure of Adverse Events, and SPAE Guidance Policy)
- Medication Error Reporting
- Infection Surveillance
- Culture of Patient Safety Survey
- Environmental Safety Rounds and Assessment
- Patient Experience Survey
- Leadership Walk-around and Tracers
- National Patient Safety Goal Dashboard
- Annual Leapfrog (NQF Safe Practices) Survey
- Sentinel Event Alert Compliance
- Institute for Safe medication Practices(ISMP) and other industry Alerts
- Employee feedback survey

Identification, reporting, and management of patient safety events

1. To effectively improve processes and systems, health care providers should not be fearful of punishment or retribution for reporting mistakes.
2. An accessible multifaceted non-punitive, just culture reporting system exists .
3. Errors and accidents are tracked in an attempt to establish trends and patterns, to learn from them and prevent reoccurrence.
4. Healthcare providers participate in reporting and developing improved processes to effectively evaluate errors and near misses.
5. Reporting errors and near misses are a critical component of the MountainView Hospital Patient Safety Program.

The Meditech on-line incident reporting system is a tool for the documentation, investigation, and correction of patient safety issues as described in the organizational policy: RM21 Facility Event and Close Call Reporting. The Director of Risk Management coordinates this process.

Organization or Medical Staff committees refer patient safety issues to the Patient Safety Officer for review at the PSC and corrective action.

NRS 439.877 – Monitoring and Compliance

Nevada statute NRS 439.877 requires medical facilities to adopt patient safety checklists and patient safety policies. These patient safety checklists are protocols used to improve the outcomes of patients at the hospital to include:

1. Patient Discharge Process (CP120 – Discharge Planning)
2. Patient Identification Process (CP70 – Patient Identification)
3. Patient room/environment sanitation and cleaning (Sodexo 7-Step Cleaning Process)
4. Additional patient safety checklists which may be appropriate to ensure the safety of patients in the facility. These include, but are not limited to the following:
 - a. Universal Protocol (CP195 – Safe Procedural and Surgical Verification)
 - b. Central Line Insertion Bundle (CP131 – Adult Central Line/PICC (Non-Implanted_ Management)

Monitoring and oversight for compliance with these policies and checklists will be the ongoing responsibility of the Patient Safety Committee.

NRS 439.865– Infection Control Program

Nevada statute NRS 439.865 requires medical facilities have an infection control program to prevent and control infections within the medical facility, as well as an infection control policy. The Hospital's Infection Control Plan is attached as an addendum to the Patient Safety Plan and is reviewed annually. (See Appendix 3 – Infection Prevention and Control Plan)

Proactive Risk Identification and Reduction:

1. Opportunities for improvement regarding patient safety issues and hazardous conditions are identified through trending of actual or potential occurrences involving patients or visitors and/or evidence-based literature (e.g. The Joint Commission Sentinel Event Alerts).
2. When an identified opportunity for improvement is identified, it is analyzed by the involved care providers according to level of severity, frequency of occurrence, potential for harm and liability.
3. At least every 18 months, one high-risk or error-prone process is selected for Failure Mode Effect Analysis (FMEA) process. The underlying systems are examined and modified or redesigned to minimize the risk of the identified failure mode.
4. Trending of adverse events, environmental safety issues, aggregate data collection, and review of intensive assessments are part of the identification and management of risks to safety and are used to prevent reoccurrences.
5. Serious unusual occurrences and sentinel events are reviewed with determination made for intensive assessment and root cause analysis according to the Facility Event and Close Call Reporting and SPAE policies.
6. Near miss events are reviewed and root cause analysis conducted as deemed appropriate.
7. Regular communication about patient safety and risk management is conducted with designated Quality Committee, Medical Executive Committee, and the Board of Trustees. Disclosure of an adverse event to a patient is in accordance with policy. RM13: Disclosure of Adverse Events and the SPAE policy

IX. Reporting Patient Safety Results: To the PSC:

The Patient Safety Committee reviews and recommends actions on the following reports:

- Audits on Patient Safety
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)

- Culture of Patient Safety Survey
- Leapfrog Survey

To organization staff and medical staff:

Organizational staff receives patient safety results and information on:

- Lessons Learned summaries
- Culture of Safety Survey
- Patient experience survey results on patient safety components.
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Leapfrog Survey

To executive leadership and Board of Trustees:

The Board of Trustees and Executive Leadership receives periodic reports on:

- Culture of Safety Survey
- Leapfrog Survey
- Risk Management dashboard
- Patient Safety dashboard

X. EVALUATION OF CY 18 PSC / Organizational Goals

GOAL	GOAL MET	GOAL NOT MET
Reduce preventable falls with injury to zero (utilize daily falls report for data). Re-institute Patient Safety Rounds to identify safety opportunities from front line nursing and support staff.		Goal not met. Continue to strive for green compliance and/or improvement by 10% for 2019 goals.
Attain 3Q18 SHARP Metric “DVT and PE on All Inpatients” in green or improve by 10% from 3Q18 results		Goal not met. Continue to strive for green compliance and/or improvement by 10% for 2019 goals.
Achieve ≥80% hospital participation in the AHRQ Patient Safety Culture Survey. Assess survey results and develop facility specific action plan(s) based upon opportunities identified.	Goal met. Participation rate = 88%	Although participation rate goals were achieved, action plans still need to be reviewed and reinforced.

XI. CY 19 PSC / Organizational Goals:

1. Maintain ≥ 90% compliance with NPSG/Patient Safety Audits.
2. Reduce preventable falls with injury to zero (utilize daily falls report for data).
3. Re-institute HAC Attack rounding to reduce hospital acquired conditions.
4. Attain 3Q18 SHARP Metric “DVT and PE on All Inpatients” in green or improve by 10% from 3Q17 results.
5. Continue to review implementation and efficacy of 2018 AHRQ action plans.

6. Continue to participate in weekly rounding e.g., Patient Safety, Executive Leadership/Nursing leadership Safety. This encourages discussion of safety issues and fosters a culture of safety through building respect, trust and inclusion in the organization.
7. Achieve compliance with Clinical Safety Improvement Program Initiatives.

XI. Annual Review

The Patient Safety Program is reviewed annually and revised as necessary. It is submitted annually for review and approval by the Medical Executive Committee and the Board of Trustees.

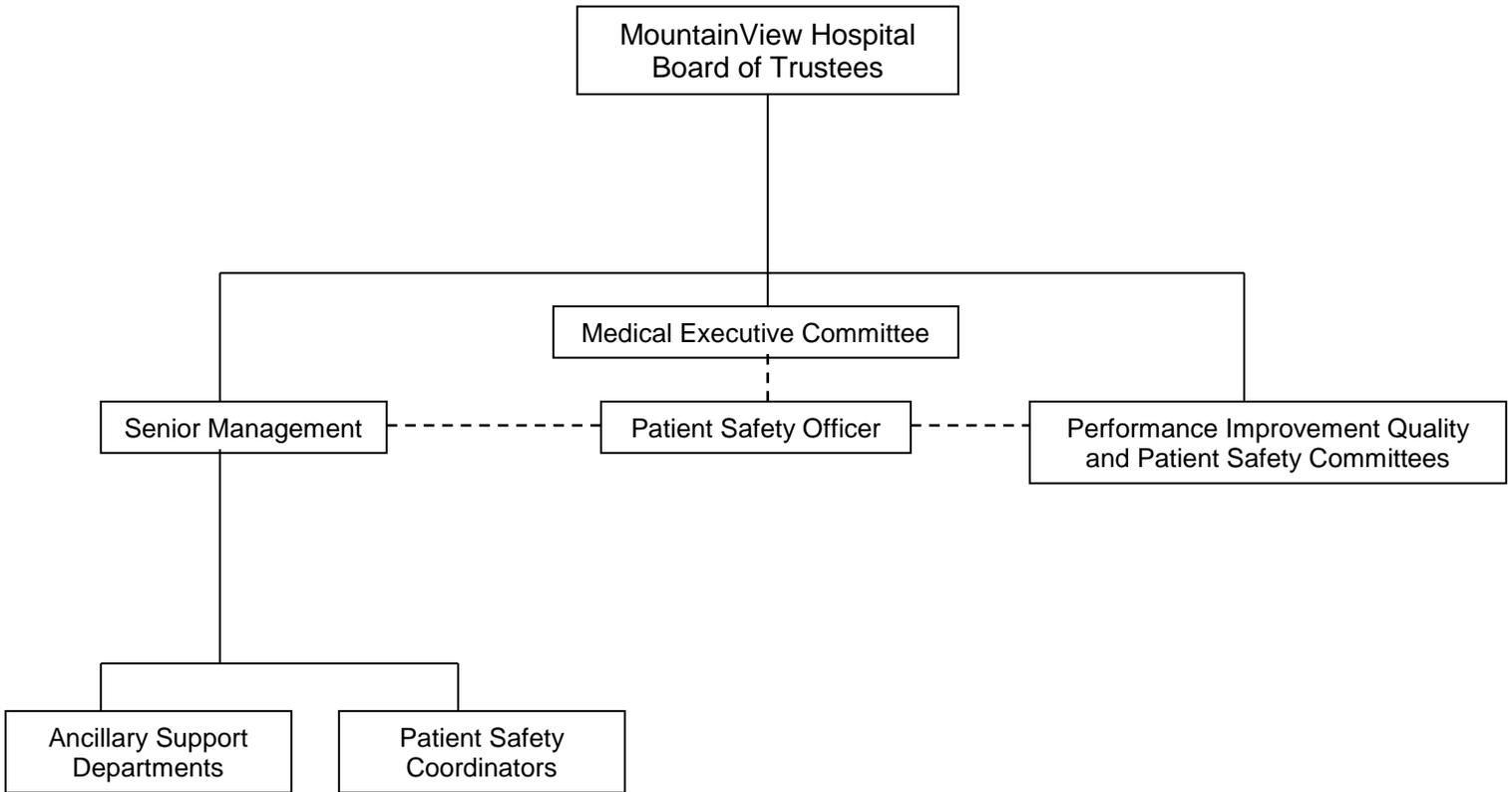
XII. The MountainView Hospital Patient Safety Program

The components of the patient safety program are outlined in Appendix One:

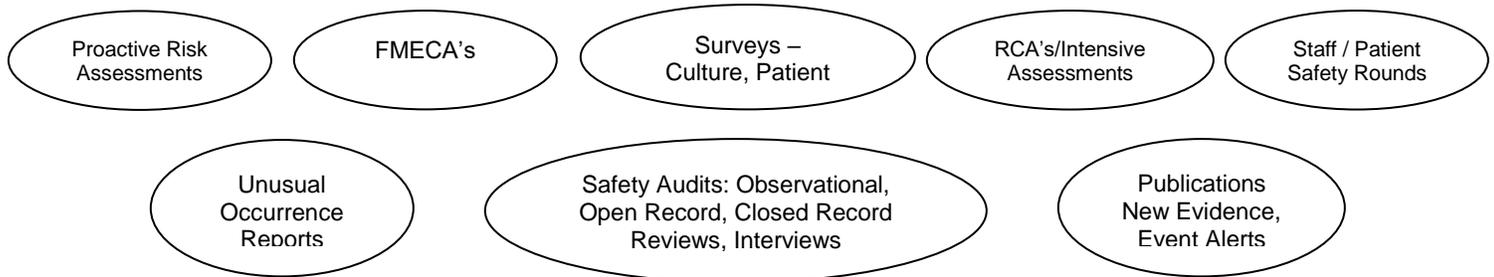
XIII. References/Authority

- The Joint Commission 2019 NPSG's
- HCA Patient Safety Organization PSO Operating Policy and Procedure
- Federal Register - Department of Health and Human Services 42 CFR Part 3 – Patient Safety and Quality Improvement

Patient Safety Program



Sources of Patient Safety Data



2019 National Patient Safety Goals Overview

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)	Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
#1: Improve the accuracy of patient identification	A: Use at least two patient identifiers when providing care, treatment or services		
	A1 Blood draw and other lab specimen collection	Blood Bank Laboratory Nursing	Random observation audits (Quarterly)
	A2 Label containers in presence of patient	Blood Bank Laboratory Nursing	Random observation audits (Quarterly)
	B: Eliminate Transfusion Errors		
	B1. Blood transfusion process: match blood or blood component to the order; match the patient to the blood or blood component; use a two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
	B2. Qualified transfusionist part of two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
	B3. Second qualified individual part of two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
#2: Improve the effectiveness of communication among caregivers	A. Report critical results of tests and diagnostic procedures on a timely basis.		
	A1. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.	Lab Nursing	Random charts and log audits (Quarterly)

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)	Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
#3: Improve the safety of using medications	A. Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.	Cardiac Imaging OR Nursing	Random observations and audits, all procedure areas (Quarterly)
	B. Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.	Pharmacy Nursing	Random chart audits (Quarterly)
	C. Maintain and communicate accurate patient medication information.	Pharmacy Nursing	Random chart audits (Quarterly)
#6: Improve the safety of clinical alarm systems.	A. Leaders establish alarm safety as a hospital priority.	Patient Safety Officer / PS Plan	Random observations and audits (Quarterly)
	B. Identify the most important alarm signals to manage.	Patient Safety Committee	Random observations and audits (Quarterly)
	C. Establish policies and procedures for managing alarms as listed above in #B.	Patient Safety Committee	Random observations and audits (Quarterly)
	D. Educate staff and LIP's about the purpose and proper operation of alarm systems for which they are responsible.	Patient Safety Committee	Random observations and audits (Quarterly)
#7: Reduce the risk of health	A. Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines	Infection Prevention Nursing	Random observations (Quarterly)

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)	Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
care-associated infections	B. Implement evidence-based practices to prevent healthcare associated infections due to multiple drug-resistant organisms (MDRO's)	Infection Prevention	MDRO Tracker (Quarterly)
	C. Implement evidence-based practices to prevent central line-associated bloodstream infections (CLABSI's).	Infection Prevention	Targeted Surveillance (Quarterly)
	D. Implement evidence-based practices to prevent surgical site infections (SSI's).	Infection Prevention	Targeted Surveillance (Quarterly)
	E. Implement evidence-based practices to prevent catheter associated urinary tract infections. (CAUTI's)	Infection Prevention	Targeted Surveillance (Quarterly)
#15: The organization identifies safety risks inherent in its patient population	A. The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]	Nursing Risk Management	(Structural process) Random chart audits (Quarterly)
Universal Protocol	A. Pre-op verification B. Site marking C. Time-out	Cardiac Medical Imaging Nursing OR	Random observations & chart audits (Quarterly)

Desert Springs Hospital Medical Center

2019 Risk Management/ Patient Safety Plan

Nevada Acute Care Division



Revised 1/2019

I. Overview

Desert Springs Hospital Medical Center endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients. Patient safety is a cornerstone of quality care and is a leadership priority. **Desert Springs Hospital Medical Center** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **Desert Springs Hospital Medical Center** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **Desert Springs Hospital Medical Center** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **Desert Springs Hospital Medical Center**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **Desert Springs Hospital Medical Center** policies. **Desert Springs Hospital Medical Center** employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

Desert Springs Hospital Medical Center mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

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

Desert Springs Hospital Medical Center recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

Desert Springs Hospital Medical Center has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective

facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

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

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

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

Desert Springs Hospital Medical Center has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **Desert Springs Hospital Medical Center** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

Desert Springs Hospital Medical Center PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.

- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Desert Springs Hospital Medical Center is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the

Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. Risk Connect (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

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

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. UHSD Acute Care Division Patient Safety Priorities, Goals and Objectives for 2019

- **Surgical and Procedural Safety:**
 - **Wrong Site Surgery.**

- Monitor through MIDAS reports, trigger tools, Cerner orders, and other intervention data. Report monthly with oversight by CPSC.
- **Opioid Analgesic Event Reduction Initiative**
 - **Goal:** decrease the number of adverse drug events related to opioids by 10% by the end of 2019.
 - Monitor through Cerner, MIDAS, ICD-10 codes, and intervention data. Report monthly with oversight by CPSC.
- **High Alert Medication Error Reduction**
 - **Goal:** 10% error reduction goal with warfarin and insulin medication administration errors.
 - Monitor through MIDAS, Cerner, PSO reports, Pharmacist Interventions. Report monthly with oversight by CPSC.
- **MIDAS Medication Event Reporting**
 - **Goal:** Maintain monthly reporting of Medication Events to at least **8% Medication Events/1000 Actual Patient Days**
 - Monitor through MIDAS. Report monthly with oversight by PSC.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls in the acute division by end of 2019.
 - Monitor through MIDAS event reporting. Report quarterly with oversight by CPSC.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to

these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

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

The patient safety plan must be reviewed and **updated annually** in accordance with the

requirements for approval set forth in this section.

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

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum

(NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				

Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.



Current Status: <i>Active</i>	PolicyStat ID: 5159178																		
	<table border="0" style="width: 100%;"> <tr><td>Origination:</td><td style="text-align: right;">06/2002</td></tr> <tr><td>Effective:</td><td style="text-align: right;">06/2018</td></tr> <tr><td>Approved:</td><td style="text-align: right;">06/2018</td></tr> <tr><td>Last Revised:</td><td style="text-align: right;">06/2018</td></tr> <tr><td>Next Review:</td><td style="text-align: right;">06/2019</td></tr> <tr><td>Owner:</td><td style="text-align: right;">: <i>Interim Director of Quality</i></td></tr> <tr><td>Policy Area:</td><td style="text-align: right;"><i>Leadership</i></td></tr> <tr><td>References:</td><td style="text-align: right;">439.800, 439.855, 439.860, 439.865, 439.870, 439.875, 439.877, 439.890, CMS CFR §482.21(e)(1), LD.03.01.01, NRS 439.835, TJC LD.04.04.05</td></tr> <tr><td>Applicability:</td><td style="text-align: right;"><i>Northeastern Nevada Regional Hospital</i></td></tr> </table>	Origination:	06/2002	Effective:	06/2018	Approved:	06/2018	Last Revised:	06/2018	Next Review:	06/2019	Owner:	: <i>Interim Director of Quality</i>	Policy Area:	<i>Leadership</i>	References:	439.800, 439.855, 439.860, 439.865, 439.870, 439.875, 439.877, 439.890, CMS CFR §482.21(e)(1), LD.03.01.01, NRS 439.835, TJC LD.04.04.05	Applicability:	<i>Northeastern Nevada Regional Hospital</i>
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Applicability:	<i>Northeastern Nevada Regional Hospital</i>																		

Patient Safety Plan

SCOPE:

House Wide

PURPOSE:

To build a system for providing safe patient care and for preventing adverse patient outcomes.

DEFINITIONS:

Adverse Event: Harm to a patient as a result of medical care or harm that occurs in a healthcare setting. Although an adverse event often indicates that the care resulted in an undesirable clinical outcome and may involve medical errors, adverse events do not always involve errors, negligence, or poor quality of care and may not always be preventable.

Error: An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

Facility-acquired Infection: A localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

1. Surgical site infections;
2. Ventilator-associated pneumonia;
3. Central line-related bloodstream infections;
4. Urinary tract infections; and
5. Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

Hazardous Condition: Any set of circumstances (exclusive of the disease or condition for which the patient is

being treated), which significantly increases the likelihood of a serious adverse outcome.

Failure Mode and Effects Analysis (FMEA): A systematic, proactive method for evaluating a process to identify where and how it might fail, and to assess the relative impact of different failures in order to identify the parts of the process that are most in need of change.

Medical Error: Any event (unanticipated outcome) within the control of a provider that results in harm and requires a new or modified practitioner order for management of the patient's medical care.

"Near Miss": Used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Near misses fall within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by The Joint Commission under its Sentinel Event Policy.

"Sentinel Events": Episodes of care that should never happen in any facility, at any time. Examples include patient abduction, wrong site procedure, and procedure on wrong patient.

Root Cause Analysis: A credible process for identifying the basic or causal factors that underlie variation in performance, including the risk of possible occurrence of a sentinel event.

Hospital Acquired Conditions: Conditions that result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis and could reasonably have been prevented through the application of evidence based guidelines. These include, but are not limited to:

1. Catheter-associated urinary tract infections
2. Central line-associated blood stream infection
3. Hospital acquired infections
4. Surgical site infections

Patient Safety Officer (PSO): The person who is designated as such by a medical facility pursuant to NRS 439.870. Northeastern Nevada Regional Hospital (NNRH) shall designate an officer or employee of the facility to serve as the PSO. The PSO will:

- Supervise reporting of sentinel events
- Serve on the patient safety committee
- Take such actions as he/she determines necessary to insure safety of patient as a result of sentinel event activity
- Report any action taken to Patient Safety Committee
- Work under the direction of the Director of Quality, Risk & Safety

POLICY:

The Safety Plan at NNRH is implemented to provide a collaboratively planned, systematic, organization-wide approach to process design and performance measurement, assessment and improvement of patient safety. With a goal of delivering the safest and highest quality health care to the residents of the community, the plan is designed and organized to support the mission, vision and values of the hospital and LifePoint Healthcare Inc.

In formulating the plan, it is recognized that the implementation of an effective patient safety plan is dependent on a participative management approach, including all organization leaders, the Governing Board, senior management, the Patient Safety Committee, departmental management, and medical staff. We believe our

plan provides our organization with the mechanisms to achieve patient safety that is expected by our customers and the community we serve.

Senior management is fully committed to the belief that improving patient safety is the most important challenge that we face in the healthcare industry and in our hospital. The purpose of the plan is to develop mechanisms to integrate and coordinate the activities of all of our healthcare staff so that patient safety is the foremost concern at every stage of every process that we conduct. Patient safety is to be the number one priority in the design of new processes, in the evaluation of existing processes and in the re-design of existing processes. The hospital-wide goal is to be proactive in preventing errors and complications.

To accomplish this goal, we are committed to comparing ourselves to national databases, searching for "best practices", studying designs of systems, and always searching for methods of strengthening our existing system designs by adding risk reduction strategies. Senior leaders regularly evaluate the culture of safety and quality using valid and reliable tools and prioritize and implement changes based on such evaluations. All individuals who work in the hospital are able to participate in safety and quality initiatives, either on an individual basis or a team approach. Staff, including the medical staff, is encouraged to discuss any areas of concern that impact patient safety and quality. Relevant literature concerning patient and staff safety is distributed throughout the hospital in the form of flyers, posters, newsletters and through staff meetings. Patients and their family members are encouraged to speak with the hospital staff concerning any safety and quality issues.

PROCEDURE:

INFECTION CONTROL

The patient safety plan works collaboratively with the infection prevention and control plan which is based on a yearly risk assessment carried out by the infection control nurse under the direction of the Infection Control committee. This plan will be developed by a nationally recognized infection control organization as approved by the State Board of Health which may include without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., The Centers for Disease Control and Prevention (CDC) of the United States Department of Health and Human Services, The World Health Organization, etc.

This facility-specific infection control plan must be developed and reviewed under the supervision of a certified infection preventionist, pursuant to NRS 439.865.

The infection control nurse will be responsible for the implementation of this plan under the approval of the Infection Control committee and Board of Directors.

In the absence of the infection control nurse, the house supervisor or director on call will be responsible for the control of infections at all times.

REPORTING OF PATIENT SAFETY EVENTS

All employees have an affirmative duty to report any occurrence which is not consistent with the routine operation of the hospital and its staff, or the routine care of a particular patient or visitor, or any situation which has potential to cause harm to patients, visitors, or employees. This duty also applies to 'near miss' situations. *Willful failure to report such occurrences may subject the employee to corrective action up to and including termination.*

Patient related occurrences and other abnormal situations will be reported and tracked using an online electronic reporting database developed by **RL Solutions** according to the NNRH Occurrence Report Policy.

NNRH will follow all statutory, regulatory and licensing agency reporting guidelines and NNRH policies.

- A. NRS 439.835 mandates that
 - a. Within 24 hours after becoming aware of a sentinel event, an employee of NNRH will notify the PSO of the event.
 - b. Within 13 days after receiving notification, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division using their occurrence reporting form.
 - c. If the PSO personally discovers or becomes aware of a sentinel event in the absence of notification by another employee, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division within 14 days after becoming aware of the sentinel event using their occurrence form.

National Quality Forum List of Serious Reportable Events:

- A. Foreign object retained after surgery
- B. Wrong surgical procedure performed on a patient
- C. Surgery performed on the wrong patient
- D. Intraoperative or immediately postoperative death in an ASA Class I patient
- E. Death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
- F. Death or disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- G. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
- H. Infant discharged to the wrong person
- I. Patient death or serious disability associated with patient elopement
- J. Suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility
- K. Death or serious disability associated with a medication error
- L. Death or serious disability associated with a hemolytic reaction to the administration of ABO/HLA incompatible blood or blood products
- M. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
- N. Stage 3 or 4 pressure ulcers not present on admission
- O. Death or serious disability due to spinal manipulative therapy
- P. Artificial insemination with the wrong donor sperm or wrong egg
- Q. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
- R. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- S. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility

- T. Patient death or serious disability associated with a fall while being cared for in a healthcare facility. This includes but is not limited to fractures, head injuries, and intracranial hemorrhage.
- U. Patient death or serious disability associated with the use of restraints or bed rails while being cared for in a healthcare facility
- V. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- W. Abduction of a patient of any age
- X. Sexual assault on a patient within or on the grounds of a healthcare facility
- Y. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a healthcare facility.

NRS439.837 mandates that the facility shall, upon reporting a sentinel event, conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event. A Root Cause Analysis (RCA) will be performed, with all staff involved with the sentinel event, with an ultimate goal of preventing a recurrence.

Once opportunities for improvement are identified, strategies for change can be developed using evidence based practice. Measures are used to determine the effectiveness of the improvement and ongoing feedback is provided to staff, the Patient Safety Committee and Quality Council.

DISCLOSURE OF EVENT TO PATIENT AND/OR FAMILY

When a sentinel event, hospital acquired condition, or an outcome that differs significantly from the anticipated outcome occurs, the patient, and when appropriate, the patient's family or the patient's designee shall be informed as soon as reasonably possible but within 7 days (NRS 439.855). The disclosure of facts of an event should occur after determination of the surrounding facts and after consultation with the Chief Executive Officer (CEO) or designee or Risk Management.

In most instances, disclosure should be handled by the attending physician who has responsibility for the overall care of the patient. The physician or his/her designee should communicate:

- Acknowledgement of the event
- Data known to date
- That a full analysis will take place
- What is currently taking place as a result of the event
- Additional data on an ongoing basis
- Measures taken to prevent recurrence
- Apologize that an event occurred.

PATIENT SAFETY COMMITTEE

The Patient Safety Committee is the interdisciplinary committee designated to manage the organization-wide patient safety program and shall be organized with strict adherence to NRS 439.875.

The Governing Board is responsible for the oversight of the Patient Safety Plan. The Patient Safety Committee functions under the guidance and with the oversight of the CEO and Quality Council, with the PSO, or designee, serving as Chairperson. The meetings, records, data gathered, and reports generated by the Patient Safety Committee are protected by the peer review privilege set forth by the Health Care Quality Improvement

Act of 1986 (Title IV of Public Law 99-660, as amended, and other applicable Nevada Statutes).

The committee shall be composed of the following members and others as the committee may from time to time add to accomplish specific goals and objectives within the authorized scope of activities outlined herein:

- A. Facility Patient Safety Officer
- B. Member of the Executive Team representing the Governing Board.
- C. Director, Quality, Risk & Safety
- D. Nursing representative
- E. Medical representative
- F. Member representing Pharmacy services
- G. Infection Prevention and Control Practitioner

At each monthly meeting, a representative from each of the medical, nursing and pharmaceutical staff, executive team or Governing Board, and the PSO or designee, should be in attendance.

Members of the Patient Safety Committee can be called ad-hoc to assist the PSO in analyzing possible sentinel events or adverse outcomes or assist with any other urgent patient safety matter.

The committee shall operate within the following scope of activities (NRS 439.870):

- Receive reports from the PSO
- Evaluate actions of the PSO in connection with all reports of sentinel events alleged to have occurred in the hospital
- Review and evaluate the quality of measures carried out by the hospital to improve the safety of patients who receive treatment at the hospital
- Review and evaluate the quality of measures carried out by the medical facility to prevent and control infection at NNRH.
- Make recommendations to the Governing Board to reduce the number and severity of sentinel events that occur at the hospital
- Adopt patient safety checklists and patient safety policies according to NRS 439.877 for use by:
 - All providers of health care who provide treatment to patients at the medical facility
 - Other personnel of the medical facility who provide treatment or assistance to patients
 - Employees of the medical facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility
 - Persons with whom the medical facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at the facility
- Patient safety checklists must follow best practice protocols to improve the health outcome of patients at NNRH according to NRS 439.877 and must include without limitation:
 - Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care
 - Checklist to ensure employees and contractors follow protocols to ensure that the room and environment of the patient is sanitary
 - Checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received discharge instructions regarding medication management

- Instructions concerning aftercare and any other instructions concerning patient's care after discharge
- Checklists adopted by NNRH include:
 - Central Line Insertion (with prompt for practitioner order)
 - Universal Protocol and Surgical Site Fire Risk Assessment/Time Out
 - Safe Surgery Checklist
 - Discharge Instructions (prescription medication instructions, aftercare instructions, any other instructions related to discharge such as follow-up appointments)
 - Daily Room Cleaning (room and environment sanitation)
 - CDC Environmental Checklist for Monitoring Terminal Cleaning
 - Pre-Oxytocin Checklist (with prompt for practitioner order)
- In addition, the Patient Safety Committee will adopt and monitor compliance with our policy for the use of two patient identifiers, hand hygiene and any other patient safety checklist and policy adopted pursuant to this section. This may include active surveillance, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.
- The Patient Safety Committee shall monitor and document the effectiveness of the patient identification policy and at least annually, review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklist and patient safety policies that may be appropriate for adoption at NNRH.
- On or before July 1st of each year, the committee submits a report to the Director of the Legislative Council Bureau for transmittal to the Legislative Committee on Health Care. The report is to include information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph above outlining checklist review (NRS 439.800).
- At least once each calendar quarter, report to the Governing Board or Executive committee regarding:
 - The number of sentinel events that occurred at the hospital during the preceding calendar quarter; and
 - The number and severity of infections that occurred at NNHR during the preceding calendar quarter
 - Any recommendations to reduce the number and severity of sentinel events and infections that occur at the hospital.
- The proceeding and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceeding and records described in NRS 49.265.

REFERENCES:

TJC Standard LD.04.04.05 (2015): Patient Safety Program Components and Governing Body Report

TJC Standard LD.03.01.01 (2015): Patient Safety Culture Regular Evaluation (survey)

CMS CFR §482.21(e)(1): Patient Safety as a component of Performance Improvement Program

Nevada Revised Statutes §439.800 and any implementing Health Division and/or State Board of Health rules and regulations: Patient Safety Plan, Program, Officer and Committee; event reporting, investigation and action plan implementation; and an annual summary of events.

Nevada Revised Statutes §439.860 and any implementing agency rules and regulations pertaining to inadmissibility of report, document or other information compiled or disseminated pursuant to the provisions of §439.800 through §439.890, inclusive, in administrative or legal proceedings.

Attachments:

No Attachments

Approval Signatures

Approver	Date
[Signature] CNO	08/2018
[Signature] s: Cardiovascular Services Director	08/2018
[Signature] Interim Director of Quality	08/2018

Applicability

Northeastern Nevada Regional Hospital

COPY

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 1 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

PURPOSE:

- The purpose of the organizational Patient Safety Plan at Grover C. Dils Medical Center is to improve patient safety and reduce risk to patients through an environment that encourages:
 - Integration of safety priorities into all relevant organization processes, functions, services, departments and programs
 - Recognition and acknowledgment of risks to patient safety and medical/health care errors
 - The initiation of actions to reduce these risks
 - The internal and external reporting of what has been found and the actions taken
 - A focus on processes and systems, and the reduction of process and system failures through use of failure mode effect analysis
 - Minimization of individual blame or retribution for involvement in a medical/health care error
 - Organizational learning about medical/health care errors
 - Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 2 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to potential or actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Grover C. Dils Medical Center. The Patient Safety Plan, developed by the interdisciplinary Safety/Environment of Care Committee and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PLAN:

- Scope of Activities:
 - The scope of the Patient Safety Plan includes an ongoing proactive risk assessments, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety.
 - One high-risk process shall be selected at least every 18 months and a proactive risk assessment shall be performed.
 - Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:
 - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 3 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015 REVIEWED: 02/07/2019

- Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel Event - an unexpected event or occurrence involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:
 - ◆ The event has resulted in an unexpected death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or
 - ◆ An event is one (1) of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):
 - Suicide of any patient in a setting where the patient receives around-the-clock care, or suicide of a patient within 72 hours of discharge
 - Unanticipated death of full term infant
 - Abduction of any patient receiving care
 - Infant abduction or discharge to the wrong family

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 4 OF: 13
	EFFECTIVE: 10/2015
APPROVED BY: Board of Hospital Trustees	REVIEWED: 02/07/2019

- Rape (by another patient, visitor or staff)
 - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
 - All identified cases of unanticipated death or major permanent loss of function associated with a healthcare associated infection
- Hospital Acquired Conditions (HACs):
 - ◆ Serious preventable event - air embolism (never event)
 - ◆ Serious preventable event - blood incompatibility (never event)
 - ◆ Catheter-associated urinary tract infections
 - ◆ Pressure ulcers
 - ◆ Hospital Acquired Infections

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 5 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015 REVIEWED: 02/07/2019

- ◆ Surgical site infections following certain elective procedures, including certain orthopedic surgeries and bariatric surgery
 - ◆ Patient falls (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
 - ◆ Manifestations of poor control of blood sugar levels, such as diabetic ketoacidosis, hypoglycemic coma
 - ◆ Please check the CMS website for the most up-to-date list of preventable conditions (HACs)
- The scope of the Patient Safety Plan encompasses the patient population, visitors, volunteers and staff (including medical staff). The plan addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:
 - Environment of Care
 - Emergency Management
 - Human Resources
 - Infection Prevention and Control
 - Information Management
 - Leadership

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 6
	OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

- Life Safety
 - Medication Management
 - Medical Staff
 - Nursing
 - Provision of Care, Treatment and Services
 - Performance Improvement
 - Record of Care, Treatment and Services
 - Rights and Responsibilities of the Individual
 - Transplant Safety
 - Waived Testing
- Methodology:
 - The Interdisciplinary Safety/Environment of Care Committee is responsible for the oversight of the Patient Safety Plan. The Safety/Environment of Care Committee Chairperson will have administrative responsibility for the plan, or the Safety/Environment of Care Committee may assign this responsibility to another member of the committee (such as the Performance Improvement Director or Risk Manager).
 - **All departments** within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Performance Improvement Director, who will aggregate occurrence information and present a report to the Safety/Environment of Care Committee on a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety/Environment of Care Committee will analyze the report information and determine further patient safety activities as appropriate.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 7 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015 REVIEWED: 02/07/2019

- Through review of internal data reports and reports from external sources (including, but not limited to, The Joint Commission sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the performance improvement priority criteria grid, the Safety/Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually. All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams). The proactive risk assessment will include:
 - Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be
 - Prioritizing the potential processes breakdowns or failures
 - For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
 - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
 - Test and implement the redesigned process
 - Identify and implement measures of the effectiveness of the redesigned process
 - Implement a strategy for maintaining the effectiveness of the redesigned process over time
- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organizationwide program.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 8
	OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:
 - Perform necessary healthcare interventions to protect and support the patient's clinical condition.
 - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
 - Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
 - Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
 - Submit the occurrence report to the Performance Improvement Department per organizational policy.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Performance Improvement Department per organizational policy.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 9
	OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:
 - No Harm Failures or Errors (including “no harm” medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
 - Mild-Moderate Adverse Outcome Failures or Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Performance Improvement Department per organizational policy.
 - ◆ Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Department of the event.
 - Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report, submitting the report to the Performance Improvement Department per organizational policy. Staff will also notify the Pharmacy Department.
 - Transfusion Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the Blood/Blood Component Transfusion Reaction Policy and Procedure.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 10 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015 REVIEWED: 02/07/2019

- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Performance Improvement Department per organizational policy.
 - Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.
 - Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to the Performance Improvement Department.
 - Hospital Acquired Conditions - staff will follow all established protocols, guidelines and policies and procedures. Staff shall complete incident reports for any breaks in technique or policy not followed.
- Established organizational policy (such as the Sentinel Event Policy) and/or the Safety/Environment of Care Committee will determine the organizational response to process/system failures and/or medical/health care errors and occurrences. All sentinel events and near miss occurrences will have a root cause analysis conducted. The determination of the Safety/Environment of Care Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
 - Further remedial action activities necessary for identified occurrences
 - Proactive occurrence reduction activities
 - Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 11 OF: 13
	EFFECTIVE: 10/2015
APPROVED BY: Board of Hospital Trustees	REVIEWED: 02/07/2019

- An effective Patient Safety Plan cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences. All staff are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Safety/Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.
 - Sentinel Events - staff members involved in a sentinel event occurrence will receive support from the Safety/Environment of Care Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Safety/Environment of Care Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Service Department, Human Resources Department and/or his or her department supervisor.
 - As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to their accrediting organization. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting the safety or quality of care concern to their accrediting organization.
 - On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.
- The Patient Safety Plan includes implementation of the recommendations set forth by the accrediting organization, or identified alternative recommendations defined by this institution, to achieve compliance with established safety standards. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified safety standards.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 12 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015 REVIEWED: 02/07/2019

- The Patient Safety Plan includes a quarterly survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Safety/Environment of Care Committee will request a report from the Information Management Committee on a quarterly basis consisting of random record review verifying compliance with informing the patient about outcomes of care. The Safety/Environment of Care Committee will analyze error reporting data submitted through the Performance Improvement Department for evidence of this information.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. The Safety/Environment of Care Committee will request a report from the Information Management Committee on a quarterly basis consisting of random record review verifying compliance with this educational process.
- The Patient Safety Plan includes consideration, at least annually, of data obtained from the organizational Information Management Needs Assessment, which includes information regarding barriers to effective communication among caregivers. The Safety/Environment of Care Committee will also request on a quarterly basis, a report from the Information Management Committee identifying the effectiveness of the organization to provide accurate, timely, and complete verbal and written communication among care givers and all other involved in the utilization of data.
- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. Education includes the staff member's right to report any safety or quality of care concerns to the organization's accrediting organization. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 13 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

- Lessons learned from a root cause analysis shall be communicated to staff who provide services or are affected by a patient safety incident. Education shall take place through the Education Department.
- Patient safety reports from the Safety/Environment of Care Committee will be submitted to the organizational Performance Improvement Committee, which exists as the oversight committee for the Safety/Environment of Care Committee. A monthly data report and recordings of meeting minutes will be forwarded to the Performance Improvement Committee, with all information submitted held under the auspices of the Performance Improvement Committee.
- A written Patient Safety Report shall be forwarded to the Governing Body, at a minimum, once per year. Information in the report shall include:
 - All system or process failures
 - Number and type of sentinel events
 - If patients and families were informed of the adverse events
 - All actions taken to improve safety, both proactively and in response to actual occurrences
 - All results of the analyses related to the adequacy of staffing and actions taken to resolve the identified problem(s)

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 1 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

PURPOSE:

- The purpose of the organizational Patient Safety Plan at Grover C. Dils Medical Center is to improve patient safety and reduce risk to patients through an environment that encourages:
 - Integration of safety priorities into all relevant organization processes, functions, services, departments and programs
 - Recognition and acknowledgment of risks to patient safety and medical/health care errors
 - The initiation of actions to reduce these risks
 - The internal and external reporting of what has been found and the actions taken
 - A focus on processes and systems, and the reduction of process and system failures through use of failure mode effect analysis
 - Minimization of individual blame or retribution for involvement in a medical/health care error
 - Organizational learning about medical/health care errors
 - Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 2 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015 REVIEWED: 02/07/2019

- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to potential or actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Grover C. Dils Medical Center. The Patient Safety Plan, developed by the interdisciplinary Safety/Environment of Care Committee and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PLAN:

- Scope of Activities:
 - The scope of the Patient Safety Plan includes an ongoing proactive risk assessments, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety.
 - One high-risk process shall be selected at least every 18 months and a proactive risk assessment shall be performed.
 - Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:
 - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 3 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015 REVIEWED: 02/07/2019

- Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel Event - an unexpected event or occurrence involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:
 - ◆ The event has resulted in an unexpected death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or
 - ◆ An event is one (1) of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):
 - Suicide of any patient in a setting where the patient receives around-the-clock care, or suicide of a patient within 72 hours of discharge
 - Unanticipated death of full term infant
 - Abduction of any patient receiving care
 - Infant abduction or discharge to the wrong family

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 4 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

- Rape (by another patient, visitor or staff)
 - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
 - All identified cases of unanticipated death or major permanent loss of function associated with a healthcare associated infection
- Hospital Acquired Conditions (HACs):
 - ◆ Serious preventable event - air embolism (never event)
 - ◆ Serious preventable event - blood incompatibility (never event)
 - ◆ Catheter-associated urinary tract infections
 - ◆ Pressure ulcers
 - ◆ Hospital Acquired Infections

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 5 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015 REVIEWED: 02/07/2019

- ◆ Surgical site infections following certain elective procedures, including certain orthopedic surgeries and bariatric surgery
 - ◆ Patient falls (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
 - ◆ Manifestations of poor control of blood sugar levels, such as diabetic ketoacidosis, hypoglycemic coma
 - ◆ Please check the CMS website for the most up-to-date list of preventable conditions (HACs)
- The scope of the Patient Safety Plan encompasses the patient population, visitors, volunteers and staff (including medical staff). The plan addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:
 - Environment of Care
 - Emergency Management
 - Human Resources
 - Infection Prevention and Control
 - Information Management
 - Leadership

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 6 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

- Life Safety
 - Medication Management
 - Medical Staff
 - Nursing
 - Provision of Care, Treatment and Services
 - Performance Improvement
 - Record of Care, Treatment and Services
 - Rights and Responsibilities of the Individual
 - Transplant Safety
 - Waived Testing
- Methodology:
 - The Interdisciplinary Safety/Environment of Care Committee is responsible for the oversight of the Patient Safety Plan. The Safety/Environment of Care Committee Chairperson will have administrative responsibility for the plan, or the Safety/Environment of Care Committee may assign this responsibility to another member of the committee (such as the Performance Improvement Director or Risk Manager).
 - **All departments** within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Performance Improvement Director, who will aggregate occurrence information and present a report to the Safety/Environment of Care Committee on a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety/Environment of Care Committee will analyze the report information and determine further patient safety activities as appropriate.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 7 OF: 13
	EFFECTIVE: 10/2015
APPROVED BY: Board of Hospital Trustees	REVIEWED: 02/07/2019

- Through review of internal data reports and reports from external sources (including, but not limited to, The Joint Commission sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the performance improvement priority criteria grid, the Safety/Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually. All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams). The proactive risk assessment will include:
 - Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be
 - Prioritizing the potential processes breakdowns or failures
 - For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
 - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
 - Test and implement the redesigned process
 - Identify and implement measures of the effectiveness of the redesigned process
 - Implement a strategy for maintaining the effectiveness of the redesigned process over time
- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organizationwide program.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 8
	OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

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 - Perform necessary healthcare interventions to protect and support the patient's clinical condition.
 - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
 - Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
 - Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
 - Submit the occurrence report to the Performance Improvement Department per organizational policy.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Performance Improvement Department per organizational policy.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 9
	OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:
 - No Harm Failures or Errors (including “no harm” medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
 - Mild-Moderate Adverse Outcome Failures or Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Performance Improvement Department per organizational policy.
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SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 10 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015 REVIEWED: 02/07/2019

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 - Further remedial action activities necessary for identified occurrences
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SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 11 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015 REVIEWED: 02/07/2019

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SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 12 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015 REVIEWED: 02/07/2019

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- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. Education includes the staff member's right to report any safety or quality of care concerns to the organization's accrediting organization. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
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SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
DEPARTMENT: HOSPITALWIDE	PAGE: 13 OF: 13
APPROVED BY: Board of Hospital Trustees	EFFECTIVE: 10/2015
	REVIEWED: 02/07/2019

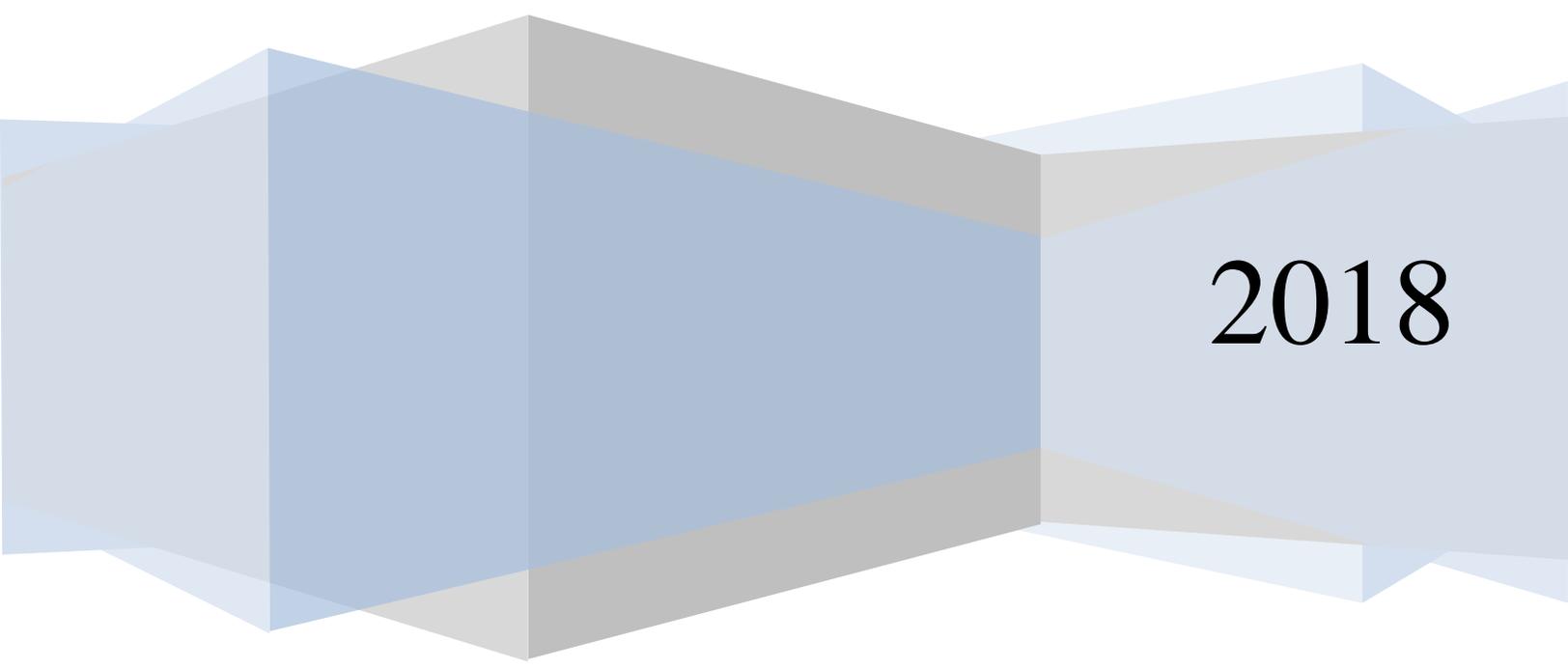
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- Patient safety reports from the Safety/Environment of Care Committee will be submitted to the organizational Performance Improvement Committee, which exists as the oversight committee for the Safety/Environment of Care Committee. A monthly data report and recordings of meeting minutes will be forwarded to the Performance Improvement Committee, with all information submitted held under the auspices of the Performance Improvement Committee.
- A written Patient Safety Report shall be forwarded to the Governing Body, at a minimum, once per year. Information in the report shall include:
 - All system or process failures
 - Number and type of sentinel events
 - If patients and families were informed of the adverse events
 - All actions taken to improve safety, both proactively and in response to actual occurrences
 - All results of the analyses related to the adequacy of staffing and actions taken to resolve the identified problem(s)

SUBJECT: Safe Environment Plan

Horizon Specialty Hospitals

Safe Environment Plan

Las Vegas and Henderson



2018

SUBJECT: Safe Environment Plan

**HORIZON SPECIALTY HOSPITALS
HENDERSON/LAS VEGAS**

DEPARTMENT: Plant Operations/Safety

SUBJECT: Safe Environment Plan - 2018

I PURPOSE

The purpose of the Safe Environment Plan is to provide a programmatic framework to reduce the risk to Horizon Specialty Hospitals. The plan includes processes that are designed to evaluate risks that may adversely affect the life or health of patients, staff and visitors.

Mission:

Horizon Specialty Hospitals are committed to providing medically complex and rehabilitative care in a long-term acute care hospital environment to ensure quality care by using goal directed strategies, safe practices and teamwork to achieve optimal outcomes. The safe environment program is designed to support patient safety and effective care by providing reliable information that allows facility management and staff to make better safety decisions and to evaluate key issues and opportunities for improvement of safety performance.

Consistent with this mission, Horizon Specialty Hospitals have established and provides ongoing support for the safe environment program described in this plan.

II SCOPE

The facility has an Environment of Care Committee (EOC) consisting of a cross representation of the facility's staff. The EOC monitors training and competence of staff and assesses conditions of the physical plant, grounds, and equipment through building inspections, environmental rounds, safety inspections and various performance improvement initiatives. Through review of reliable information, management is able to make the best decisions regarding safety concerns and to evaluate safety performance related to key issues with opportunities for improvement. The EOC monitors and evaluates all safety issues. It takes action and makes recommendations to the facility leadership, including the Administrator/Executive Officer, who is a member of the Governing Board. The EOC may issue assignments to committee members and non-committee staff for follow-up actions/improvements and completion of reports.

III FUNDAMENTALS

- A. Safety is information driven. Without appropriate information, accident and incident causing situations cannot be predicted and prevented.
- B. Department managers need appropriate information to develop an understanding of safe working conditions and safe work practices within their area of responsibility.

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015

SUBJECT: Safe Environment Plan

- C. Safe working conditions and practices are established by using knowledge of safety principles to: educate staff, evaluate existing conditions, design appropriate work environments and purchase appropriate equipment and supplies.
- D. The safe environment program establishes processes for identifying, evaluating and alleviating practices or situations that have a potential to harm patients, staff, or visitors or damage to property.
- E. The safe environment program establishes processes to reduce the occurrences, the probability and the effects of person-to-person violence.

IV GOALS

- A. Comply with accepted standards of safety.
- B. Provide a safe, secure and therapeutic environment for patients, staff and visitors.
- C. Integrate safety practices into daily operations.
- D. Identify opportunities to improve performance.

V ORGANIZATION AND RESPONSIBILITY

- A. The Administrator receives regular reports on activities of the safety program from the EOC. The Administrator reviews reports and, as appropriate, communicates safety related concerns about identified issues and regulatory compliance.
- B. The Administrator reviews reports and, as necessary, communicates concerns about key issues and regulatory compliance to appropriate departments, services and staff. The administration collaborates with appropriate departments, services and staff to establish operating and capital budgets for the safe environment program.
- C. The Safety Officer (SO) has responsibility for identification, collection and analysis of information regarding safety deficiencies, development of plans for improvement, accident and injury prevention and investigation, and emergency response. Training of staff and volunteers is facilitated by the Director of Plant Operations.
- D. The EOC coordinates processes within the Environment of Care Standards. Membership on the EOC is by appointment from the Administrator and includes representatives from administration, clinical services and support services. The EOC meets as often as is necessary on a regular basis to receive reports and to conduct reviews of safety issues. Additional meetings may be scheduled at the request of the Safety Officer.

SUBJECT: Safe Environment Plan

- E. The Administrator authorizes key staff to take immediate and appropriate action in the event of an emergency. An emergency is a situation that poses an immediate threat to life or health, or threatens to damage equipment or buildings.
- F. Department managers are responsible for the orientation of new staff members to the department, program and job specific safety procedures.
- G. Individual staff members are responsible for learning and following job and task specific procedures for safe operations. Individual staff members are also responsible for learning and using reporting procedures.

VI PROCESSES OF THE SECURITY PROGRAM

A. Risk Assessment

The Horizon Specialty Hospitals Safety officer is responsible for managing the safe environment program risk assessment process. When issues arise the Safety Officer will consult with the Administrator in regard to approval for actions or guidance.

1. Horizon Specialty Hospitals pro-actively performs risk assessments in a manner that allows for comprehensive evaluation of existing aspects of the organization, and the impact of proposed changes. The goal of risk assessment is to reduce the likelihood of future incidents that have the potential for injury, accident, or other loss to patients, staff, visitors and facility assets.
2. Horizon Specialty Hospitals address other environmental considerations when performing risk assessment functions. For example, when planning demolition, construction, or renovation work, the facility conducts a proactive risk assessment using risk criteria to identify hazards that could potentially compromise patient care in occupied areas of the facility buildings.

Use of the risk assessment process triggers organization linkages with other aspects of the safe environment program. For example, a proposed change may indicate a need to create or revise existing safety policies and procedures; hazard surveillance in the areas affected; safety orientation and education programs; and safety performance improvement monitoring. Horizon Specialty Hospitals' SO is responsible for coordinating the impact of proposed changes with other aspects of the safe environment program.

Horizon Specialty Hospitals' SO and department managers are responsible for performing follow-up activities on issues, findings, observations or recommendations that result from applying the risk assessment process. Horizon Specialty Hospitals' EOC reviews reports related to the safe environment program risk assessment processes.

B. Reporting and Investigating

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015

SUBJECT: Safe Environment Plan

The safe environment program uses a variety of reporting methods to document activities. The SO, Risk Manager, Chief Nursing Officer/Chief Operations Officer (CNO/COO) and Human Resources Director share responsibility for managing, reporting and investigating incidents.

Reports of patient and visitor incidents/accidents are made using the appropriate forms. These reports are reviewed by the EOC, QAPI and Infection Control. Aggregate information is reviewed by the EOC.

Reports of significant property damage are directed to the SO.

One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

C. Hazard Surveillance

The Director of Plant Operations (DOPO) is responsible for managing the hazard surveillance process including product safety recalls. Hazard surveillance surveys are conducted to evaluate staff knowledge and skill, EOC compliance, observe current practices, assess/evaluate environmental conditions and other risk factors. Results of hazard surveillance activities serve to improve safety policies and procedures, risk assessments, orientation and education programs and staff performance.

Surveys are conducted on a frequency that meets the needs and requirements of the various areas that are surveyed. All inpatient care areas are scheduled for at least two annual hazard surveillance surveys. Non-patient care areas are scheduled for at least one hazard surveillance survey each year. Areas or systems under special circumstances are scheduled for additional surveys as required.

Additional hazard surveillance surveys are performed during the application of Interim Life Safety Measures (ILSM). Hazard surveillance surveys to assure free and unobstructed exiting for construction projects are performed daily.

The EOC is responsible for oversight of the hazard surveillance program. This includes ensuring that the information received includes an analysis of data collected, identification of trends and patterns, risk reduction strategies, corrective action recommended or taken and persons responsible.

Individual department managers are responsible for initiating appropriate action on findings applicable to their scope of authority or responsibility. The SO is responsible for coordinating follow-up activities with individual department managers to ensure each finding is brought to closure.

D. Environment of Care Committee

SUBJECT: Safe Environment Plan

The EOC includes selected members of administration, clinical and support services.

The Safety Officer through the EOC is responsible for managing the process of examining safety issues. Effective use of information is dependent on written and verbal reports from a number of different functions within Horizon Specialty Hospital. Reports are used to identify and communicate problems, time-sensitive issues and general information about periodic or structured activities to the EOC. Reports help the EOC to prioritize, develop and approve recommendations for improvement of patient, staff and visitor safety. It is the responsibility of the EOC Chairperson to review the content of reports submitted.

The EOC processes information via a discussion of findings and recommendations outlined in the minutes for each meeting. The minutes also document recommendations the EOC has developed and otherwise approved.

E. Performance Improvement Monitoring

The SO through the EOC has overall responsibility for coordinating the ongoing performance monitoring and the performance improvement monitoring for each of the seven functions associated with Management of the Environment of Care. The SO is responsible for all monitoring associated with the safe environment program.

The intent of establishing performance monitoring is to improve the safe environment program through objective measures of demonstrated performance. **The results of measurement are reported through appropriate channels including the facility's leadership and when appropriate to relevant components of the facility wide patient safety program.** Performance improvement is an important aspect of the Safe Environment Plan. Ongoing performance monitoring serves as an indicator of continued effectiveness of the safe environment program and is a mechanism to identify performance improvement opportunities.

F. Policies and Procedures

The SO has overall responsibility for coordination of the EOC policy and procedure process including coordination with individual department managers.

Individual department, program, and site managers are responsible for their specific safety policy and procedure process. These safety policies and procedures address issues such as: safe operations, use of hazardous equipment or processes and use of personal protective equipment. The SO assists department managers in development of new safety policies and procedures and participates in reviewing existing policies and procedures.

Organization-wide safety policies and procedures are communicated to staff via normal communication channels. Department managers are responsible for distribution of safety policies and procedures and ensuring they are enforced. Each staff member is responsible for knowing and following all safety policies and procedures.

SUBJECT: Safe Environment Plan

Both facility-wide and departmental, program and site safety policies and procedures are reviewed at least every three years. Additional interim reviews are performed on an as needed basis.

Horizon Specialty Hospital has established a procedure for implementing new policies, procedures and practices. Administrative policy determines the form, structure and organization of all policies, procedures and practices.

G. Safety Officer Appointment

The Administrator is responsible for managing the Safety Officer Appointment process.

The Administrator is responsible for selecting a qualified individual who is capable of overseeing the development, implementation and monitoring of the safe environment program. By appointment, the SO is assigned overall operational responsibility for the safe environment program. The SO is made known to all staff through normal communication channels.

The SO is accountable to the Administrator and is guided by a written duty description. For example, the SO reviews changes in law, regulation and standards; assesses the need to make changes to general safety, procedures, training; and performs other activities essential to the implementation of the safe environment program.

The SO directs the integration of environment of care monitoring and response activities into the hospital-wide patient safety program.

H. Immediate Threat Statement

The Administrator is responsible for managing the process for identifying individual(s) who may intervene whenever conditions pose an immediate threat to life or health or threatens damage to equipment or buildings.

To support this process an Immediate Threat Statement is defined in the Situation Response and Crisis Communication Manual. This policy is intended to define authority and responsibility in situations that pose an immediate threat; to the life or health of patients, staff and visitors; or risk major damage to buildings or property. The goal of the Immediate Threat Statement is to identify and mitigate an immediate threat situation before such situation results in loss and to return the facility to normal conditions as quickly as possible.

Key staffs are empowered to intervene immediately and to take appropriate action(s) to mitigate the effects of such situations. Such delegation of authority enables the facility to implement the policy, swiftly and decisively, on a twenty-four hours a day/seven days a week basis.

The Immediate Threat Statement is approved by the Administrator; is revised as necessary and reviewed at least every three years.

SUBJECT: Safe Environment Plan

I. Grounds and Equipment

The DOPO is responsible for managing the facilities grounds and external equipment maintenance processes. The Horizon Specialty Hospital provides patient care, treatment or activities outside of facility buildings. There are patient activities conducted outside of facility buildings that require supervision by facility staff.

The DOPO is responsible for scheduling and performing maintenance to facility's grounds and external equipment. DOPO makes regular rounds of various areas to observe and correct conditions and ensure safety of facility's grounds and external equipment.

Facility grounds includes for example: courtyards, shrubs and trees, sidewalks, roadways, parking lots, lighting, signage and fences. External equipment includes for example: electrical switch gear, transfer switches, and fuel storage. The nature of these types of external equipment is such that limited or infrequent preventive maintenance is required. Corrective maintenance is completed on an as needed basis.

J. Annual Evaluation

The SO has overall responsibility for coordinating the annual evaluation of each of the seven functions associated with management of the Environment of Care. The SO is responsible for completing the annual evaluation of the safe environment program. An evaluation of the program's objectives, scope, performance, effectiveness and the Safe Environment Plan is included in each annual evaluation.

In the completion of the annual evaluation, the SO utilizes a variety of source documents such as policy review and evaluation, incident report summaries, risk assessment activities, meeting minutes and statistical information summaries. In addition, other relevant sources of information are used for the annual evaluation, such as results of monitoring studies, reports from accrediting and certification agencies and goals and objectives. The annual evaluation of the security program is used to further develop educational programs, policies, performance monitoring and improvement.

The annual evaluation is reviewed and approved by the EOC. The annual evaluation is then presented to the Performance Improvement Committee, Executive Management Committee, Medical Executive Committee and Governing Board. Minutes or other means of communications from the Governing Board are received, reviewed and acted upon by the EOC.

VII WORKER SAFETY

The EOC and Infection Control Committee are responsible for identifying activities to reduce the risk of staff/worker injuries.

A. Reporting and Investigating

The safe environment program uses a variety of reporting methods to document activities. The SO, Risk Manager and Human Resource Director share responsibility for managing,

SUBJECT: Safe Environment Plan

reporting and investigating incidents of injuries, occupational illnesses and accidents. Reports are made using the appropriate forms. This information is reviewed by the EOC, QAPI and Infection Control. Aggregate information is reviewed by the EOC.

One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

B. Orientation and Education

The Director of Plant Operations has overall responsibility for organizing the orientation and education program for each of the seven functions associated with Management of the Environment of Care. Department managers are responsible for assuring the safe environment program orientation and education is implemented.

The Director of Plant Operations is responsible for conducting the general orientation program with current information on general safety processes to new staff members as soon as possible but within 30 days of employment. Every new staff member participates in a general orientation program that includes information related to the safe environment program. Critical Environment of Care information is provided prior to staff being allowed to work independently. The Human Resource Department records attendance for each new staff member who completes the general orientation program. Attendance records are maintained in the Education and Human Resource Department.

Each department manager is responsible for providing their new staff members with safe environment orientation specific to their department. The goal of these orientation programs is to provide new staff members with current job specific safety and hazard information.

All staff members of the facility must participate in mandatory continuing education at least once each year, which includes information specific to the safe environment program. This requirement may be satisfied through completion of a self-learning packet or attendance at a regularly scheduled facility-wide continuing education program. The Human Resource and Education Departments maintains records of all completed training.

Various Departments collaborate with the Facilities Department and individual managers, as appropriate, for developing content and supporting material for general and department specific orientation and continuing education programs. The content and supporting materials utilized are reviewed and revised as necessary.

The Human Resource Department reports information on orientation and continuing education data during the reporting period to the EOC.

VIII SMOKING

Horizon Specialty Hospitals have a policy to reduce the risks to patients who smoke, including possible adverse effects on treatment; risks of passive smoke to others; and risks of fire

SUBJECT: Safe Environment Plan

Patients, staff and visitors are prohibited from smoking in all facility regulated buildings and campus.

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015

**HUMBOLDT GENERAL HOSPITAL
CRITICAL ACCESS HOSPITAL
118 East Haskell St.
Winnemucca, Nevada 89445**

POLICY/PROCEDURE

Date:
Revised:

**Developed by: Quality Services Director
Revised by:
Department: All HGH Departments
Page 1 of 1 Page**

**Reviewed by: _____
Approved: _____
Approved: _____
Effective: _____**

POLICY: PATIENT SAFETY PLAN

In compliance with NRS 439.800-439.890, Humboldt General Hospital shall develop, in consultation with the providers of health care who provide treatment to patients at the medical facility, an internal patient safety plan to improve the health and safety of patients who are treated at this medical facility.

HGH shall develop a patient safety plan to include without limitation:

- a) The patient safety checklists and patient safety policies most recently adopted pursuant to NRS 439.877.
- b) An infection control program to prevent and control infections within the medical facility. To carry out the program, HGH shall adopt an infection control policy. The policy must consist of:
 - 1) The current guidelines appropriate for HGH’s scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, without limitation, the Association for Professionals in Infection control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United State Department of Health and Human Services, The World Health Organization and the society for Healthcare Epidemiology of America: and
 - 2) Facility-specific infection control developed under the supervision of a certified infection preventionist.

HGH shall designate the house supervisors as the person who is responsible for infection control when the infection control officer is absent to ensure that someone is responsible for infection control at all times.

The Patient Safety Plan shall be submitted to the governing board for approval in accordance with the requirements of NRS 439.865. After the HGH Patient Safety Plan is approved, all providers of health care who provide treatment to patients at HGH shall be notified of the plan and of the requirements of the plan. Compliance with the HGH Patient Safety Plan shall be required.

The Patient Safety Plan shall be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

HGH shall designate an employee to serve as the patient safety officer. The person who is designated as the patient safety officer shall:

- a) Serve on the Patient Safety Committee

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

HGH shall designate an employee to serve as the infection control officer. The infection control officer shall:

- a) Serve on the patient safety committee.
- b) Monitor the occurrences of infections at Humboldt General Hospital to determine the number and severity of infections
- c) Report to the patient safety committee concerning the number and severity of infections at HGH. Take such action as he or she determines is necessary to prevent and control infections alleged to have occurred at HGH.
- d) Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

HGH will ensure that the infection control officer has successfully completed a nationally recognized basic training program in infection control, which may include, without limitation, the program offered by the Association for Professionals in Infection Control and Epidemiology, Inc., or a successor organization. The infection control officer shall complete at least 4 hours of continuing education each year on topics relating to current practices in infection control and prevention. HGH shall maintain records concerning the certification and training required by this section.

HGH shall establish a patient safety committee.

- a) The HGH Patient Safety Committee must be composed of:
 - 1) The patient safety officer of the medical facility.
 - 2) The infection control officer of the medical facility.
 - 3) At least three providers of health care who treat patients at HGH, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.
 - 4) One member of the executive or governing body of the medical facility.
- b) A patient safety committee shall meet at least once each month.
- c) The patient safety committee shall:
 - 1) Receive reports from the patient safety officer pursuant to NRS 439.870.
 - 2) Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
 - 3) Review and evaluate the quality of measures carried out by HGH to improve the safety of patients who receive treatment at the medical facility.
 - 4) Review and evaluate the quality of measures carried out by HGH to prevent and control infections at the medical facility.
 - 5) Make recommendation to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at HGH.
 - 6) At least once each calendar quarter, report to the HGH executive or governing body of the medical facility regarding

- i. The number of sentinel events that occurred at HGH during the preceding calendar quarter;
 - ii. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
 - iii. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- 7) Adopt patient safety checklists and patient safety policies as required, review the checklists and policies annually and revise the checklists and policies as the patients safety committee determines necessary.
- d) The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265

The Patient Safety Committee, established pursuant to NRS 439.875 by a medical facility, shall adopt patient safety checklists and patient safety policies for use by:

- a) Providers of health care who provide treatment to patients at HGH;
- b) Other personnel of the medical facility who provide treatment or assistance to patients;
- c) Employees of the HGH who do not provide treatment to patients but whose duties affect the health or welfare of the patients at HGH, including, without limitation, a janitor or HGH; and
- d) Person with whom HGH enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at HGH.

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

- a) Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
- b) Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
- c) A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - 1) Proper instructions concerning prescription medications;
 - 2) Instructions concerning aftercare; and
 - 3) Any other instruction concerning his or her care upon discharge.
- d) Any other checklists which may be appropriate to ensure the safety of patients at the medical facility

The patient safety policies must include, without limitation:

- a) A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of health care. The personal identifiers may include, without limitation, the name and date of birth of the patient.

- b) A policy regarding the nationally recognized standard of precautionary protocols to be observed by providers of health care at the medical facility including, without limitation, protocols relating to hand hygiene.
- c) A policy to ensure compliance with the patient safety checklists and patient safety policies, which may include, without limitation, active surveillance. Active surveillance may include, without limitation, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

The Patient Safety Committee shall:

- a) Monitor and document the effectiveness of the patient identification policy adopted.
- b) At least annually, review the patient safety checklists and patient safety policies adopted pursuant to this section as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
- c) On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if the person, without malice:

- a) Reports a sentinel event to a governmental entity with jurisdiction or another appropriate authority;
- b) Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event;
- c) Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority;
- d) Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or
- e) Performs any other act authorized pursuant to [NRS 439.800](#) to [439.890](#), inclusive.

If Humboldt General Hospital:

- (a) Commits a violation of any provision of [NRS 439.800](#) to [439.890](#), inclusive, or for any violation for which an administrative sanction pursuant to [NRS 449.163](#) would otherwise be applicable; and
- (b) Of its own volition, reports the violation to the Administrator, such a violation must not be used as the basis for imposing an administrative sanction pursuant to [NRS 449.163](#).

If HGH commits a violation of any provision of [NRS 439.800](#) to [439.890](#), inclusive, and does not, of its own volition, report the violation to the Administrator, the Division may, in accordance with the provisions of subsection 3, impose an administrative sanction:

- (a) For failure to report a sentinel event, in an amount not to exceed \$100 per day for each day after the date on which the sentinel event was required to be reported pursuant to [NRS 439.835](#);
- (b) For failure to adopt and implement a patient safety plan pursuant to [NRS 439.865](#), in an amount not to exceed \$1,000 for each month in which a patient safety plan was not in effect; and
- (c) For failure to establish a patient safety committee or failure of such a committee to meet pursuant to the requirements of [NRS 439.875](#), in an amount not to exceed \$2,000 for each violation of that section.



**TAHOE
FOREST
HEALTH
SYSTEM**

Origination Date: 12/2005
Last Approved: 08/2018
Last Revised: 08/2018
Next Review: 08/2019
Department: *Quality Assurance /
Performance Improvement -
AQPI*
Applies To: *System*

Patient Safety Plan, AQPI-02

PURPOSE:

To develop, implement, and evaluate a patient safety program for the Tahoe Forest Health System which includes Tahoe Forest Hospital (TFH) and Incline Village Community Hospital (IVCH), (hereinafter referred to as the "organization").

The Tahoe Forest Hospital District (TFHD) Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of this Patient Safety Plan that will identify, evaluate, and take appropriate action to prevent unintended patient care outcomes (adverse events), as well as protect the TFHD's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

This policy is integrated with a companion policy, Risk Management Plan AQPI-04.

The Tahoe Forest Hospital District endorses the National Quality Forum set of "34 Safe Practices for Better Healthcare." Further, the District ascribes to the tenets and practices of the Just Culture program in the investigation of near-misses, adverse events and unexpected/unintended outcomes.

A. SCOPE & APPLICABILITY

1. This is a Health System program empowered and authorized by the Board of Directors of Tahoe Forest Hospital District. Therefore, it applies to all services and sites of care provided by the organization.

B. RECITALS

1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.
3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results. Patients and patient representatives are informed of unexpected/unintended outcomes as described in 4.8.1

below.

C. AUTHORITY & RESPONSIBILITY

1. **Governing Body**

- a. The Governing Body, through the approval of this document, authorizes a planned and systematic approach to preventing adverse events and implementing a proactive patient safety plan. The Governing Body delegates the implementation and oversight of this program to the Chief Executive Officer (hereinafter referred to as the "Senior Leader") and request that the Medical Staff approve the creation of a Patient Safety Committee. The Medical Staff Quality Committee will serve as the Patient Safety Committee for TFHD and the IVCH Medical Staff Committee will serve as the Patient Safety Committee for IVCH.

2. **Senior Leader**

- a. The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the structures and processes necessary to accomplish this objective. The Senior Leader delegates the day-to-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.

3. **Medical Staff**

- a. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California evidence Code Section 1157 relating to medical professional peer review and for the State of Nevada subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.
- b. The Patient Safety Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from and distribute information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization. The Patient Safety Committee shall recognize and reinforce that the members of the Medical Staff are responsible for making medical treatment recommendations for their patients.

4. **Management Team**

- a. The Management Team, through the Director of Quality and Regulations, is responsible for the day-to-day implementation and evaluation of the processes and activities of this Patient Safety Plan.

5. **Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment C)**

- a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.

6. **Patient Safety/Medical Staff Quality Committee**

1. The Patient Safety Committee shall:
 1. Receive reports from the Director of Quality and Regulations and/or the Patient Safety Officer

2. Evaluate actions of the Director of Quality and Regulations and/or Patient Safety Officer in connection with all reports of adverse events, near misses or unexpected/unintended outcomes alleged to have occurred
3. Review and evaluate the quality of measures carried out by the organization to improve the safety of patients who receive treatment in the Health System
4. Make recommendations to the executive committee or governing body of the Health System to reduce the number and severity of adverse events that occur
5. Report quarterly, and as requested, to the executive committee and governing body
6. The Patient Safety Committee members shall include, at least, the following individuals:
 1. Director of Quality and Regulations or the Patient Safety Officer designee, if not one and the same
 2. Members of the medical staff
 3. One member of the nursing staff (CNO or designee)
 4. Director of Pharmacy
 5. Medical Director of Quality
 6. Risk Manager, if not one and the same as the Patient Safety officer
 7. Chief Operating Officer

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
4. Contribute to PI activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes
6. Manage losses, claims or litigation when adverse events occur.
7. **Designing or Re-designing Processes**
 - a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.
8. **Identification of Potential Patient Safety Issues**
 - a. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Areas of focus include:
 - i. Processes identified through a review of the literature
 - ii. Processes identified through the organization's performance improvement program

- iii. Processes identified through Safety Risk Management Reports ([Event Reporting AQPI-06](#)) and sentinel events ([Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35](#))
- iv. Processes identified as the result of findings by regulatory and/or accrediting agencies
- v. The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"
- vi. Adverse events or potential adverse events as described in HSC 1279.1. (Attachment A)
- vii. Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network. (Attachment B)
- viii. Adverse events associated with misconnecting intravenous lines, enteral feeding tubes, and epidural lines.
- ix. TFHD specific results from the AHRQ Patient Safety Culture Survey

9. Performance Related to Patient Safety

- a. Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety. In addition, the following will be measured:
 - b. The perceptions of risk to patients and suggestions for improving care.
 - i. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.
 - c. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.
 - d. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of the Just Culture.

10. Proactive Risk Assessments

- a. Through implementation of this Patient Safety Plan, and integrated with the Risk Management Plan and other performance improvement processes, the Department of Quality and Regulations will systemically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm. Identified opportunities for improvement will then undergo redesign (as necessary) to mitigate any risks identified. A patient safety risk assessment by an external resource will be performed at least every 24 months and reported to the organization as described herein under "reporting structure." A focused patient safety risk assessment will be performed annually by the Patient Safety Officer and reported to the organization as described herein under "reporting structure."

11. Responding to Errors

- a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include care for the involved caregivers as noted below in 4.6.1. To that end, the organization has established a variety of policies and procedures to address these

issues,

- b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of the Just Culture. Management of these types of errors is described in [Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35](#).

12. Supporting Staff Involved in Errors

- a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: ([Care for the Caregiver Involved in Sentinel or Adverse Events, AGOV-1602](#))

13. Educating the Patient on Error Prevention

- a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

14. Informing the Patient of Errors in Care

- a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/families is described in the Administrative policy, [Disclosure of Unanticipated Adverse Outcome to Patients/Families AGOV-1503](#).

15. Reporting of Medical Errors

- a. The organization has established mechanisms to report the occurrence of medical errors both internally and externally.
- b. Errors will be reported internally to the appropriate administrative or medical staff entity.
- c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, [Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35](#).

16. Evaluating the Effectiveness of the Program

1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.

Related Policies/Forms: [Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35](#); [Event Reporting AQPI-06](#); [Disclosure of Unanticipated Adverse Outcome to Patients/Families AGOV-1503](#); [Care for the Caregiver Involved in Sentinel or Adverse Events, AGOV-1602](#); [Risk Management Plan AQPI-04](#); The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

All revision dates:

08/2018, 02/2017, 12/2016, 03/2014, 02/2014, 11/

Attachments:



[image1.jpeg](#)

[Process Flow for Risk Manager-Patient Safety.pdf](#)

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	08/2018
	Dawn Lockwood: Physician Quality Reporting Specialist	08/2018

COPY

Harmon Hospital

**Patient Safety
Plan**

Patient Safety Plan

Table of Contents

Commitment to Patient Safety	1
Mission, Vision, and Values	1
Scope and Purpose	1
Roles and Responsibilities	2
Roles and Responsibilities	3
Objectives and Goals of the Quality and Patient Safety Plan	6
Components and Methods	6
Root Cause Analysis	7
Model for Improvement	8
Data Collection and Reporting	9
Assessment of the Patient Safety Plan	10
Patient Safety Checklists and Patient Safety Policies	11
Approval of Patient Safety Plan	13
Reference	13
Appendix A: Terms and Definitions	14
Appendix B: PDSA Worksheet	16
Appendix C: Patient Safety Goals	17
Appendix D Leadership Policy Safety	21
Appendix E Incident Reporting	
Appendix F Root Cause Analysis	
Appendix G Fishbone Diagram	
Appendix H Sentinel Event Registry	
Appendix I	

Patient Safety Plan

Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, Harmon Hospital's Patient Safety function as part of the Quality Assessment Quality Improvement program promotes:

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

Scope and Purpose

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

- ✦ Patient safety
- ✦ Visitor safety
- ✦ Employee safety

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

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

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

- ✦ All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- ✦ Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- ✦ Customer based including patients, families, and visitors.

Patient Safety Plan

- ✚ Promote systems thinking.
- ✚ Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to NRS 439.875, a medical facility shall establish a Patient Safety Committee (PSC). This Committee should ensure that the Patient Safety Plan is promoted and executed successfully. The Patient Safety Function is incorporated into the Quality Assessment Performance Improvement Committee (QAPI)

The Patient Safety Function Organization



Patient Safety Plan

Roles and Responsibilities

In accordance with NRS 439.875, a patient safety committee must be comprised of:

- ✚ The infection control officer of the medical facility;
- ✚ The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- ✚ At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- ✚ One member of the executive or governing body of the medical facility.
- ✚ The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

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

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

Patient Safety Plan

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

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

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

Root Cause Analysis (RCA) Team Responsibilities

- ✚ Root Cause interviews,
- ✚ analysis,
- ✚ investigation, and
- ✚ corrective action plan implementations
- ✚ Participates in the RCA meetings and discussions.
- ✚ Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on NRS 439.870)

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

Infection Control Officer Responsibilities (based on NRS 439.873)

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

RCA team leader Responsibilities

Patient Safety Plan

- ✚ Organize and coordinate the RCA process.
- ✚ Assemble and encourage a supportive and proactive team.
- ✚ Assign investigative and implementation tasks to the team members.

Patient Safety Plan

- ✚ Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- ✚ Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- ✚ Monitor goals and progress towards completion of the Corrective Action Plans.
- ✚ Provide training, education and direction to create RCA processes that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

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

The Quality Assessment and Performance Improvement Committee (including the Patient Safety function) will meet monthly to accomplish the following:

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

A RCA Team and meeting will meet as needed to accomplish the following:

- ✚ Define the healthcare issues or potential risks.
- ✚ Conduct Root Cause Analysis
 - ✓ Reviewing and analyzing the data.
 - ✓ Reviewing the RCA process and quality improvement related activities and timelines.
 - ✓ Brainstorming issues or the potential risks by using the fishbone diagrams.
 - ✓ Identify the contributing factors and conduct the Root Cause

- ✚ A meeting agenda and minutes noting follow-up tasks will be kept.

Patient Safety Plan

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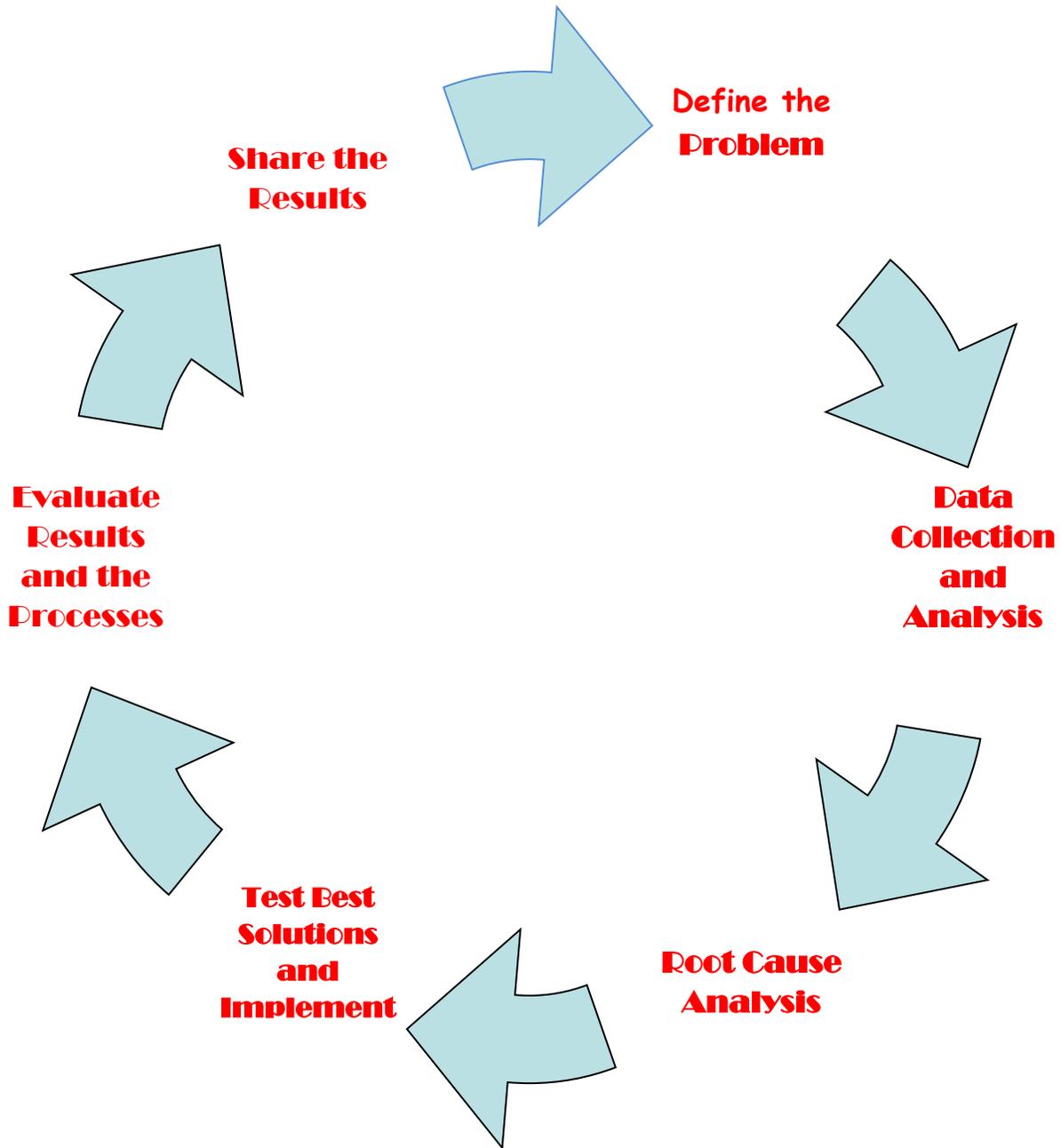
Components and Methods

- ✚ Pursuant to NRS 439.837 and NAC 439.917, within 45 days after reporting a sentinel event pursuant to NRS 439.835, the medical facility shall conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”
- ✚ Harmon Hospital will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study-Act (PDSA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.

Root Cause Analysis

- ✚ A **Root Cause Analysis** is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.
- ✚ **Root cause analysis and action plan framework table**
 - ✓ Introduced by the Joint Commission.
 - ✓ It contains 24 analysis questions.
 - ✓ It guides the organization to the steps in a root cause analysis.
 - ✓ Not all the questions apply to all the events or cases.
 - ✓ This table can be used individually or with the fishbone diagram.
- ✚ **5 Whys**
 - ✓ Technique will be used by Harmon Hospital to explore the cause and effect relationship underlay a problem.
 - ✓ One can find the root causes by asking “why” no less than five times.
 - ✓ This technique can be used individually or as a part of the fishbone diagram.

RCA Improvement Process



Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems.

General categories used include:

- ✓ people,
- ✓ methods
- ✓ materials,
- ✓ measurements,
- ✓ education,
- ✓ procedures,
- ✓ process,
- ✓ location,
- ✓ environment, etc.

RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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

- ✓ if the change is an improvement.
- ✓ Adjust, adopt, or abandon
- ✓ Study process and results
- ✓ Implement the change
- ✓ Develop plan based on the identified root causes

Patient Safety Plan

What are we trying to accomplish?

How will we know a change is an improvement?

What change can we make that will result in an improvement?

□

Plan--Do-- Study-- Act

Plan

Develop Plan based on identified root causes

Do

Implement the change

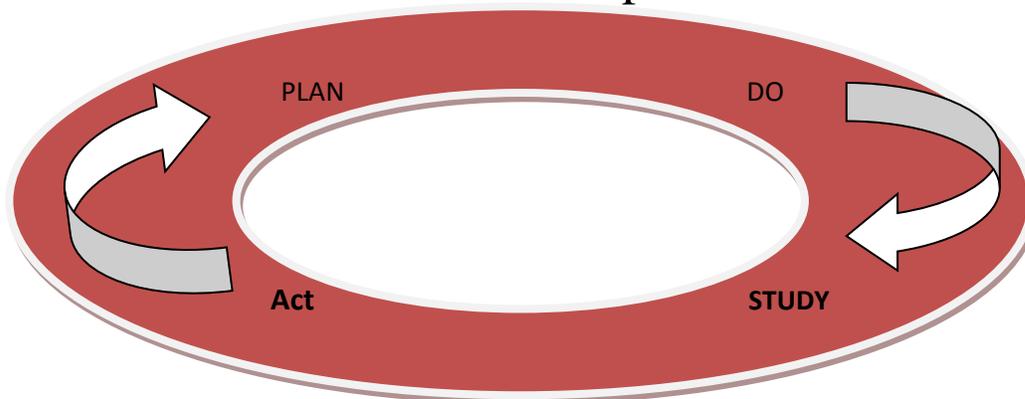
Study

Analyze process and results

Act

Adjust, adopt or abandon to repeat cycle as needed

Cycle continues until maximum improvement is achieved



The cycle is defined as follows:

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

Patient Safety Plan

+ Do-

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

+ Study –

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

+ Act—

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

Data Collection and Reporting

Data should drive any quality and patient safety effort. Harmon Hospital is using a Fundamental LTC corporate database for tracking the sentinel events and other incidents such as falls, hospital acquired pressure ulcers and medication variations for internal data collection.

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

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

Patient Safety Plan

Ongoing Reporting and Review Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report	1) Sentinel event quarterly report	1) Quality and Patient Safety Plan update
2) Severity of infection report	2) Severity of infection report	2) Checklists
3) RCA assessment	3) Review and evaluate the measure of improvement of patient safety	3) Policies reviewing and revising
4) Infection reports	4) Review and evaluate the measurement to prevent and control infections	

Patient Safety Checklists and Patient Safety Policies

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

- ✚ Providers of healthcare who provide treatment to patients at the facility;
- ✚ Other personnel of the facility who provide treatment or assistance to patients;
- ✚ Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; a
- ✚ Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- ✚ Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- ✚ Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- ✚ A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - ✚ Proper instructions concerning prescription medications;
 - ✚ Instructions concerning aftercare;
 - ✚ Any other instructions concerning his or her care upon discharge; and
 - ✚ Any other checklists which may be appropriate to ensure the safety of patients at the facility.
- ✚ The patient safety policies must include, without limitation:
 - ✓ A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
 - ✓ A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

Patient Safety Plan

- ✓ A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

The policy must consist of:

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

Patient Safety Plan

Approval of Patient Safety Plan

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

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

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

References

- ✓ Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- ✓ Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- ✓ CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- ✓ Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- ✓ Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- ✓ Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- ✓ Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- ✓ Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- ✓ Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- ✓ Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- ✓ Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

APPENDIX A

DEFINITIONS

Patient Safety Plan

Sentinel Event

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.
2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:
 - (a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or
 - (b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

** If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by 2002 Special Session, 13; A 2005, 599; 2013, 217)

Medical Harm

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: (NRS 439.802)

- ✚ “Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:
 - ✓ Surgical site infections;
 - ✓ Ventilator-associated pneumonia;
 - ✓ Central line-related bloodstream infections;
 - ✓ Urinary tract infections; and
 - ✓ Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

(Added to NRS by 2005, 599; A 2009, 553)

Medical facility (NRS 439.805) Medical facility” means:

- ✚ A hospital, as that term is defined in NRS 449.012 and 449.0151;
- ✚ An obstetric center, as that term is defined in NRS 449.0151 and 449.0155;
- ✚ A surgical center for ambulatory patients, as that term is defined in NRS 449.0151 and 449.019; and
- ✚ An independent center for emergency medical care, as that term is defined in NRS 449.013 and 449.0151.

(Added to NRS by 2002 Special Session, 13)

Near miss:

Patient Safety Plan

- ✚ An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting:

- ✚ Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk:

- ✚ Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Patient Safety Plan

- ✚ **Catheter Associated Urinary Tract Infection (CAUTI):** A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Patient Safety Plan

-  **Catheter Associated Urinary Tract Infection (CAUTI):** A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

 **Central Line Associated Bloodstream Infections (CLABSI):** Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B PDSA WORKSHEET

PDSA WORKSHEET
Harmon Hospital

TOPIC:		
PERSON COMPLETING WORK SHEET		Date:
Telephone:	e-mail	Quarter:
QAPI Committee Members		
Medical Director		
Physician Member		
Physician Member		
CEO		
DQM-Patient Safety Officer		
Infection Control Officer		
Facility Safety Officer		
Team Members:		
AIM: Describe the Overall Goal team wishes to achieve		
Plan		
1. List the tasks needed to set up this test of change		
2. Predict what will happen when the test is carried out		

3. List the steps to develop the test-who what and when			
Steps	By whom	By when	Desired outcome
DO: (Describe what actually happened when you ran the test including any problems and unexpected findings)			
STUDY: (Describe what you learned and did you meet your measurement role?)			
Did you meet measurement goal? Explain:		Summarize what was learned: success, failure, unintended consequences etc.	
Act: (Describe what you concluded from this cycle)			
Based on what your learned, Pleas indicate the action to be considered.		Describe what modifications to the plan will be made for the next cycle based on what you have learned	
<input type="checkbox"/> Adapt: modify changes and repeat the PDSA cycle			
<input type="checkbox"/> Adopt: standardize and expand changes throughout org.			
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle			
<input type="checkbox"/> Other:			

APPENDIX C

Patient Safety

Goals

Patient Safety Goals Objectives and Action Plan

Goal	Objectives	QTR 1	QTR 2	QTR 3
Safety and Quality method for improvement educations for all staff	<ul style="list-style-type: none"> ✓ Utilize Institute of Healthcare Improvement free online training <ul style="list-style-type: none"> ▪ On Demand: An Introduction to the Model for Improvement ▪ On Demand: Building Skills in Data Collection and Understanding Variation ▪ On Demand: Using Run and Control Charts to Understand Variation ▪ On Demand: Improvement Skills to Empower Front-Line Nurses 			
Design systems/processes to anticipate errors and prevent or identify them before they cause harm	<ul style="list-style-type: none"> ✓ Conduct proactive risk assessment areas identified as high risk ✓ Utilize retrospective chart review to identify areas of concern ✓ Establish an automatic surveillance process 			
Establish structures for reporting events and a process for managing reports in the event reporting system	<ul style="list-style-type: none"> ✓ Educate and train staff to utilized incident reporting process for all events with potential for patient harm ✓ Establish standardized reports based on events that occurred as well as near missed ✓ Evaluate the potential and actual harm caused by these events. ✓ Develop processes to prevent actual and potential harm 			

Goal	Objectives	QTR 1	QTR 2	QTR 3
Develop a culture of safety within the organization	<ul style="list-style-type: none"> ✓ Ensure staff feels safe and supported when they report medical errors/ near misses or when they voice concern about patient safety ✓ Conduct a Culture of Safety Survey with all staff ✓ Identify key areas for improvement based on the Culture of Safety Survey 			
Establish Safety Priorities and benchmarks	<ul style="list-style-type: none"> ✓ Establish a Patient Safety Dashboard with national measures and benchmarks ✓ Facilitate the development of action plans for safety measures not meeting benchmarks 			
Improve all levels of communication and particularly with handoff and transition patient information	<ul style="list-style-type: none"> ✓ Ensure a standardized process for handoff communication at change of shift ✓ Utilize checklists for key transition processes such as RTA and Discharge ✓ Educate staff on key measures to improve communication such as Huddles and post event assessments 			
Initiate Monitoring process for National Patient safety goals	<ul style="list-style-type: none"> ✓ Focus on the following 5 until solidly in place: <ul style="list-style-type: none"> • Two identifiers • Critical value management • Suicide assessment • Hand washing, PPE • Fall prevention 			

Appendix D

Leadership Policy

for Patient Safety

Patient Safety Program

PURPOSE

To establish guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety Program designed to improve patient safety by preventing medical/healthcare errors and reducing risks to patients.

POLICY

The Patient Safety Program is a coordinated and systematic approach to create an information infrastructure and build a better evidence base for patient safety critical to reducing medical/healthcare errors and improving patient safety. The program meets the requirements of Patient Safety Standard, and integrates with the Quality Assessment and Performance Improvement (QAPI) Plan and the Sentinel Event Policy, and is endorsed by the medical staff and Leadership.

Patient Safety Program:

Harmon Hospital is committed to making the safety of all patients, employees, physicians and visitors a leadership priority for organizational performance improvement. The Patient Safety Program is an integral part of the QAPI Plan that includes processes to:

- Establish and maintain a just culture of safety throughout the hospital;
- Promote safety by recognizing and reducing risks and hazardous conditions that result in medical/healthcare errors and patient injury;
- Support a strong internal non-punitive reporting mechanism;
- Facilitate the rapid redesign of unsafe care processes and systems in response to actual and potential adverse events;
- Support ongoing proactive efforts through implementation of known safe practices;
- Promote communication and coordination among individuals and departments to minimize risk to patients;
- Support sharing of knowledge to effect behavior change and organizational improvement to reduce risk and improve patient safety;
- Support notification of patients and when appropriate, their family, of unplanned outcomes;
- Establish a data collection system to monitor performance of new or revised processes including patient, family, and staff input, needs, perceptions of risk to patients, and suggestions for improvement.

Organizational Culture:

An organizational culture has been established by the leaders that support the effective reduction of medical/health care errors and other factors that contribute to unintended adverse patient outcomes. This culture is based on the principles of organization-wide cooperation and communication and encourages:

- The recognition and acknowledgement that preventing errors and improving safety for patients requires a systems approach in order to modify the conditions that contribute to errors;
- A focus on processes and systems;
- Minimization of individual blame or retribution for involvement in a medical/health care error;
- The internal reporting of what has been found and the actions taken to reduce risk; and
- Organizational learning about medical/health care to effect behavioral changes in order to improve patient safety.

The organizational culture is also reflective of Harmon Hospital's Philosophy, which supports the patient's right to be informed about the outcomes of their care, including unanticipated outcomes.

An effective Patient Safety Program cannot exist without optimal reporting of actual or potential medical/healthcare errors and occurrences. Therefore, it is the intent of Harmon Hospital to adopt a just, non-punitive approach in its management of errors and occurrences. All personnel will report suspected or actual medical/healthcare errors and may do so without fear of reprisal.

Scope of Activities:

The Patient Safety Program at Harmon Hospital is an organization-wide program that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety program supports and encourages the active participation of each person in order to have an effective program.

When processes, functions or services are designed or redesigned, information internal and external to the organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or service.

Undesirable patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns, or trends vary significantly and undesirably from those expected;
- Performance varies significantly and undesirably from that of other organizations;
- Performance varies significantly and undesirably from recognized standards; or
- When a sentinel event has occurred.

Minimally, data from the following areas will be analyzed and action plans developed reflective of the findings:

- Initial risk assessment
- On-going proactive risk assessments utilizing internal and external resources
- Aggregate event report reflective of all medical/healthcare errors, with and without adverse outcomes, including but not limited to:
 - Medication errors, to include delays in administration
 - Adverse drug reactions
 - Transfusion reactions
 - Patient falls
 - Sentinel events, actual and near misses
 - Hazardous conditions
 - Restraint issues
 - Medical record legibility issues

- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety
- Others as defined by Harmon Hospital

Leadership:

Hospital leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety Program. These responsibilities include the following:

- Fostering an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.
- Establishing a culture in which communication flows freely regardless of authority gradient;
- Ensuring that a defined, on-going, proactive program for identifying risks to patient safety and reducing medical/health care errors is fully implemented and includes responses to actual and potential events, as well as addresses two high risk processes for proactive intensive assessment based on internal data and information published in JCAHO Sentinel Event Alerts and other literature sources;
- Ensuring that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Providing for mechanisms to measure, analyze and manage variations in the performance of defined processes that affect patient safety;
- Allocating adequate resources, including personnel, time, information systems, data management support and staff training to support the performance improvement processes associated with reducing risk and improving patient safety; and
- Annually evaluating the patient safety plan for its effectiveness in reducing risk and improving patient safety.

Patient Safety Coordinator:

The Risk Manager has been designated the *Patient Safety Coordinator* and as such, has the administrative responsibility for the Program. Specific responsibilities include:

- Day to day responsibility for the ***Patient Safety Program***
- Along with the Safety Officer, collection, trending and analysis of data
- Quarterly reporting of trended data and actions taken to improve the quality and safety of patient care to the Patient Safety Committee and senior leadership
- Working with Patient Safety Committee to achieve the goals of the Patient Safety Program

Patient Safety Committee:

The Patient Safety Committee, in collaboration with the chair of the committee and the Patient Safety Coordinator, has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety Program within the organization;
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to, risk assessments, sentinel event report/alert information, and event reporting information from a variety of available resources including the event reporting system;
- Selection of at least two high-risk patient safety processes (one related to medication errors and one related to mistake management) for proactive risk assessment and improvement annually; and
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts.

Physicians:

Physicians are responsible, as participants in the patient safety program, for reporting errors or near misses, and participating on teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (or comparable designee), shall clearly explain these outcomes to the patient, and when appropriate, the family.

Patients/Families/Visitors:

Patients and families are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to the patient's health;
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner;
- Asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.

Patients and visitors will be provided with educational materials explaining these expectations and their role in reducing risk and improving patient safety at the time of admission. Some patients may also be included in the process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

Hospital Departments and Staff:

Hospital departments and staff have the following responsibilities:

- Active participation in the Patient Safety Program;
- Participation in all education activities and process implementation;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among care givers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in the information needs assessment, staff surveys and other processes that request information regarding the Patient Safety Program.
- Participate in the measurement activities for process and outcomes which will be utilized for data driven decisions and improve quality of care and services.

PROCEDURE

1. Proactive Risk Assessment Activities

1.1. The Risk Manager, in collaboration with the Patient Safety Committee, will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk assessment activities will include, but not be limited to the following:

1.1.1. An initial patient safety risk assessment evaluating known high risk processes/procedures that have associated risks;

1.1.2. On-going risk assessments based on internal and external data, including sentinel event alerts;

- 1.1.2.1. Focused risk assessments as determined by the Patient Safety Committee, senior leadership and/or Quality Council
 - 1.1.2.2. Selection of patient safety process improvements and risk reduction activities utilizing the priority setting criteria of Gerald Champion RMC.
 - 1.1.2.3. The information needs assessment conducted by Harmon Hospital will include identification of barriers to effective communication among caregivers.
 - 1.1.2.4. Patient satisfaction surveys will include a question determining how the patient/family thinks the facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.
 - 1.1.2.5. Staff surveys will be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety as well as the staff's willingness to report medical/health care errors.
- 1.2. Risk assessment activity results will be aggregated and analyzed. Appropriate action plans will be developed in response to the results with the goal of reducing the actual, potential or perceived risk to patient safety.

2. Event Reporting

- 2.1. When an unplanned event occurs, the patient care provider will do the following:
- 2.1.1. Perform the necessary healthcare interventions to support the patient's clinical condition
 - 2.1.2. Perform the necessary interventions to contain the risks to others
 - 2.1.3. Notify the patient's attending physician
 - 2.1.4. Preserve any information related to the event including physical evidence.
 - 2.1.5. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Reporting form and in the medical record
 - 2.1.6. Notify immediate supervisor of the event
 - 2.1.7. Submit the Event Report form to the medical center's Risk Manager
- 2.2. Identification of potential unsafe condition that may affect patient safety:
- 2.2.1. Individuals identifying such a condition will immediately report such to their supervisor, and document on the Event Report form
 - 2.2.2. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated
 - 2.2.3. Submit the Event Report form to the medical center's Risk Manager

3. Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention

- 3.1. Patient safety related event reporting data within the scope of the Patient Safety Program and all risk assessment results will be aggregated and presented to the Executive Safety Committee for analysis quarterly. Based on the analysis of this data, any actual or potential sentinel events and other internal and external data including JCAHO Sentinel Event Alerts and other current literature, proactive action plans will be developed to include the following:
 - 3.1.1. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation;
 - 3.1.2. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
 - 3.1.3. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
 - 3.1.4. Redesign of the process and/or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
 - 3.1.5. Test and implement the redesign process;
 - 3.1.6. Identification and implementation of measures of the effectiveness of the redesigned process;
 - 3.1.7. Implementation of a strategy for maintaining the effectiveness of the process over time.

4. Response to Reported Adverse/Sentinel Events

- 4.1. Harmon Hospital shall respond to all reported potential and actual adverse/sentinel events as described in the sentinel event policy.
- 4.2. Minimally, all significant adverse events will be analyzed utilizing a team of individuals to conduct a root cause analysis and/or a failure mode and effects analysis, implement an action plan to reduce further risk to patients and establish measures of effectiveness as described above in Section III A.
 - 4.2.1. The following events always elicit an intense analysis:
 - 4.2.1.1. Confirmed transfusion reactions;
 - 4.2.1.2. Significant adverse drug reactions;
 - 4.2.1.3. Significant medication errors and hazardous conditions;
 - 4.2.1.4. Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
 - 4.2.1.5. Significant adverse events associated with anesthesia use.
 - 4.2.2. A root cause analysis is performed when a sentinel event occurs.

- 4.3. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
 - 4.3.1. A non-punitive approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
 - 4.3.2. Involved staff should be involved in the root cause analysis process.
 - 4.3.3. The department manager will provide on-going support to the staff member as needed.
 - 4.3.4. Whenever necessary, Employee Assistance Programs will be offered as support to the involved employee.
- 4.4. Harmon Hospital will notify patients and/or family members, when appropriate, of unplanned outcomes.
Staff will follow the policy and procedure on “Disclosure of Unanticipated Adverse Outcomes to Patients/Families.”

5. Facility Education

5.1. Staff Education

- 5.1.1. General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety.
- 5.1.2. Specific Patient Safety Program training at orientation and annually thereafter will include:
 - 5.1.2.1. An overview of the Patient Safety Program
 - 5.1.2.2. Staff's role and responsibilities in the Patient Safety Program
 - 5.1.2.3. Event reporting, including the events requiring reporting and the process for reporting events.
 - 5.1.2.4. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care;
 - 5.1.2.5. Examples of specific job-related aspects of patient safety.
- 5.1.3. Staff participating at a higher level of the Patient Safety Program will receive appropriate training necessary to understand and complete their assigned responsibilities.

5.2. Physician Education

- 5.2.1. An overview of the Patient Safety Program will be provided to physicians at time of initial appointment and periodically thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
- 5.2.2. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety Program.

6. Patient Safety Program Reporting and Review

- 6.1. Patient Safety related data and information reports will be provided at least quarterly to the Patient Safety Committee.
- 6.2. A summary report of data, other internal and external information, as well as all actions taken by the Patient Safety Committee and/or specific patient safety related teams will be submitted to the Quality Council, Quality and Utilization Management Committee the Medical Executive Committee and Governing Board.
- 6.3. Annually, the Patient Safety Program will be evaluated for effectiveness and the program updated to reflect the results of risk assessments of patients, families and staff. The review shall include a summary of the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.

- 6.3.1. The review will be approved by Patient Safety Committee, Medical Staff Executive Committee
 - 6.3.2. Will be submitted to the governing body for review and approval.

REFERENCES:

Conditions of Participation- (CMS) Standards
The Joint Commission Standards
Sentinel Event Policy

Addendum A
Patient Safety Policy and Procedure
Definitions

Error: An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome.

Near Miss: Used to describe any process variation which did not affect the outcome, but for which recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by the Joint Commission under its Sentinel event Policy.

Hazardous Condition: Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of a serious adverse event.

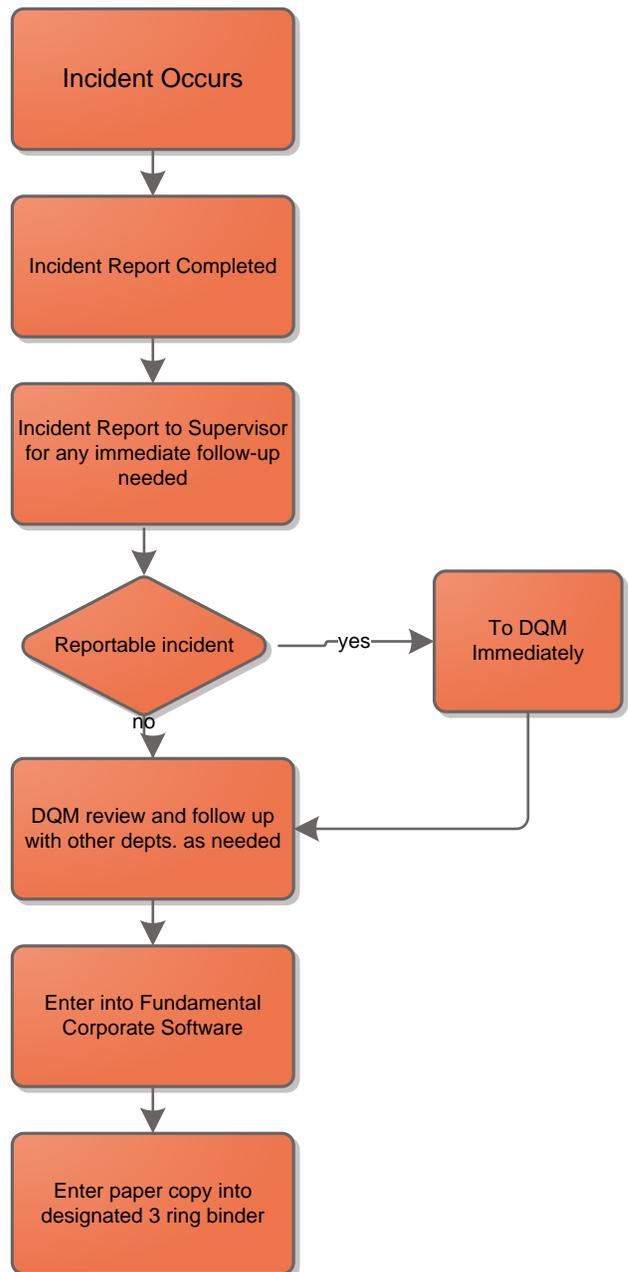
APPENDIX E

INCIDENT REPORTING

Incident Report Process (Non-Medication incident)

1. Incident is identified by Hospital staff
2. Incident report is completed
3. Incident Report is given to Nursing Supervisor for immediate review and follow up as needed.
4. Any additional assessment and investigation is completed and documented. Supporting documentation is attached to the Incident Report.
5. After incident information and follow up Completed the information and incident report is given to the Director of Quality Management (DQM).
6. DQM reviews for any immediate actions/notifications including interface with other departments involved.
7. DQM gives incident report to Patient Advocate for entering into Fundamental incident reporting software on Fundamental site.
8. Patient Advocate enters the Incident into the Incident Reporting Module.
9. Patient Advocate then has the paper copy of the incident with supporting documentation filled in 3 ring binders for maintaining incident reports.
10. Incidents are filed in binder by date. The binder is kept in the DQM office when filing is completed.
11. Reports are maintained on site for 3 years and then filed and sent to Iron Mountain for a total of 7 years.

Incident
Process
Flow Chart

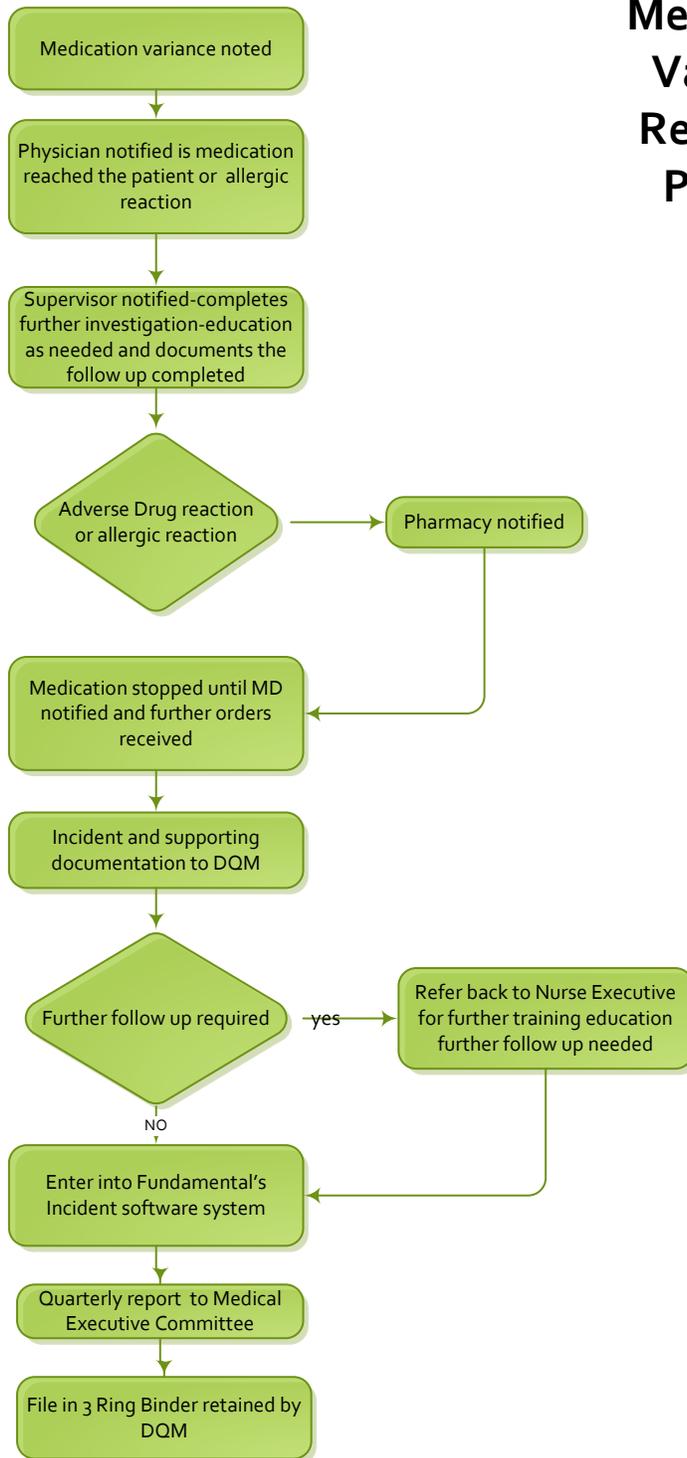


Incident Reporting Process

Medication Variances

1. Medication Variation is noted. (error, transcription error, medication not available, adverse drug reaction, etc.)
2. Individual noting the error completes the incident report.
3. Physician notified of medication error (only if wrong medication reached the patient, route, reached the patient or an obvious allergic reaction)
4. If the medication error reached the patient the physician notifies the patient, guardian or Power of Attorney of the error and any impact this had on the patient. This interaction must be documented in the patient's medical record.
5. Nursing Supervisor notified.
6. Nursing Supervisor investigates the medication variation issue and ensures all required follow up is completed.
7. Nursing Supervisor documents all and follow-up in a report to the nurse executive.
8. Staff education is completed at the time of the incident with the nurses involved. (Nursing Supervisor). Nurse Executive may do further education or further follow –up as appropriate at a later date.
9. Pharmacy is notified promptly for Adverse Drug Reactions and or allergic reactions.
10. Incident Report and all supporting investigative data are sent to the Director of Quality Management (DQM).
11. DQM will review medication variation, investigation and follow-up. Notifies the Nurse Executive if more follow-up or further investigation is needed.
12. DQM or designee enters the medication error into the Fundamental Corporate Software program.
13. Medication variations are reported to the Pharmacy and Therapeutics function at the Medical Executive Committee Quarterly.

Medication Variance Reporting Process



Appendix E

Checklist and Action Plan for Safety

Process Change	In Place	Not done	Will adopt	Responsible-By when
Conduct Fall Risk Injury Assessment upon admission	✓			
Reassess risk daily and when change in condition occurs	✓			
Implement patient specific interventions to prevent falls/injuries	✓			
Communicate risk across the team, handoff forms, visual cues, huddles	✓		improve	Forms, Quality Risk-Mar 14th
Rounds every 1-2 hrs for high-risk patients, address needs, (e.g. 4 Ps – pain- potty –position change pressure relief- personal needs) Combine w/ other tasks	✓		improve	Nursing Service April 30. 2017
Individualize interventions,. Use non-skid floor mats, float heels, hip protectors, individualized toileting schedule, adjust rounds to patient needs	✓			
Medication Review by pharmacy, avoid unnecessary hypnotics, sedatives			✓	Pharmacy Department-April 19th
Multidiscipline input for falls	✓			
Prevention measures from PT, OT, MD, RN, Pharm D	✓			Pharmacy Department-April 19th
Include patients and families in efforts to prevent falls/injury. Educate regarding fall/injury prevention measures, stay with patient	✓			
Hold post-fall huddles immediately after falls, analyze how and why, implement changes in intervention to prevent further falls	✓		improve	

Reference: Checklist to Improve Patient Safety. June 2013 Health Research & Educational Trust

Action Plan for Improvement

Improvement item	Findings	Actions to be taken	Responsible - timeframe
Communicate risk across the team, handoff forms, visual cues, huddles	<p>Information is communicated but forms would increase quality and accuracy of reports.</p> <p>Patient specific visual cues in place</p> <p>Huddles are not consistently conducted immediately post fall-no form utilized for consistent review. Analysis forms but are not conducted by team.</p>	<ol style="list-style-type: none"> 1. Develop hand off form for patients who have history of falls and have fallen HH, 2. Develop, educate and implement use of Post Fall Huddle form to improve consistency of change needed post fall 	
Rounds every 1-2 hrs for high-risk patients, address needs, (e.g. 4 Ps –pain- potty – position change pressure relief- personal needs) Combine w/ other tasks	Inconsistency in timeliness and consistency with 4 Ps	<ol style="list-style-type: none"> 1. Reeducate to rounds process 2. Re-implement process 3. Measure and report compliance 	
Hold post-fall huddles immediately after falls, analyze how and why, implement changes in intervention to prevent further falls	Inconsistency with post fall huddles-Form not used to ensure consistency of review	<ol style="list-style-type: none"> 1. Develop Post Fall Huddle form 2. Educate and train staff on use of form 3. Implement process 4. Measure and Report compliance 	

Compliance Checklist

Organization: _____ Department/Unit: _____

Date of Review: _____ Reviewer: _____

Environment of Care [CAH, HAP, NCC]

✓ N/A

- All equipment on one side of hall
- No equipment plugged in within hallways
- Nothing parked in hall longer than 30 minutes
- Top of linen cart covered; solid bottom on cart
- Nothing other than linen on linen carts

Clean Utility or Storage Room [AHC, CAH, HAP, NCC, OBS]

✓ N/A

- Oxygen tanks upright, in holder, full and empty tanks separated with signage
- Top of linen cart covered when not in use; solid bottom on cart
- Door to hall closed (not propped open)

Soiled/Dirty Utility Holding Room [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✓ N/A

- Biohazard trash contained
- Nothing under sink

Housekeeping and Security [AHC, BHC, CAH, HAP, NCC, OBS]

✓ N/A

- Trash contained
- Drawers locked, as appropriate

Crash Cart [AHC, CAH, HAP, NCC, OBS]

✓ N/A

- Daily checklist completed
- No clutter on top
- Locked (including extra locks secured)
- No expired medications or supplies noted

Medication Carts/Storage Areas [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✓ N/A

- No open single-use vials; all discarded after use
- Opened multidose vials dated
- MAR/eMAR closed when not in use
- Pill crushers/splitters cleaned
- All doors/drawers locked when unused

Medication Refrigerator/Freezer [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✓ N/A

- Temperature checks completed; response to variances recorded

- Opened multidose vials dated
- Discharged patient medications managed
- No expired medications

Medications/Solutions [AHC, BHC, CAH, HAP, NCC, OBS, OME]

✓ **N/A**

- No unsecured medications, sharps, or syringes
- No expired medications or solutions
- No predrawn syringes

Point-of-Care Glucose Meters [AHC, BHC, CAH, HAP, NCC, OME]

✓ **N/A**

- Cleaned
- Controls and strips dated when opened
- QC performed, per manufacturer's guidelines

Patient Care [AHC, CAH, HAP, NCC, OBS]

✓ **N/A**

- All patients wearing correct ID band
- Fall-risk patients wearing bracelets; signage up
- Any nonambulatory patients (on gurneys or in wheelchairs) in hall covered with dignity
- Trays and snacks delivered
- Call lights functional and within patient reach
- Alarms answered
- Confirmed confidentiality of medical records
- Isolation precautions implemented if ordered
- Reviewed hand hygiene policy with staff and ensured sanitizer dispensers are full
- Reminded staff to perform time-out for any invasive procedures
- Reviewed medication administration with staff

Chart Review (New Admits) [CAH, HAP, NCC]

✓ **N/A**

- Home medication record completed
- Administration database completed
- TO/VO/critical value documentation completed

Appendix F

ICRA

Infection Control Risk Assessment

INFECTION CONTROL RISK ASSESSMENT (ICRA) FORM

Project Name: _____

Project Location: _____

Project Manager: _____

IDENTIFY THE TYPE --

Step 2: Identify the Area Risk Group

Identify the locations of all groups/spaces that are potentially impacted from the project. This should include all areas surrounding the project. If there is more than one risk group that will be affected, use the higher risk group.

- Low Risk: No patient care or occupancy. No laboratory research or materials present.
- Medium Risk: Most active laboratories, outpatient areas, patient occupancy and support service areas.
- High Risk: Clean Rooms, areas with high value equipment subject to damage from dust, High Risk Outpatient and all inpatient areas.

IDENTIFY THE RISK-

Step 3: Determine Class (I – IV) of Risk Mitigation Measures Required

Project Type

Area Risk Group	Type A	Type B	Type C	Type D
Low Risk	I	I	II	IV
Medium Risk	I	II	III	IV
High Risk	II	III/IV	III/IV	IV

All work/construction projects that require Class II, III or IV risk mitigation measures will require approval of a dust control plan prior to the start of work.

Step 4: Risk Mitigation Measures

Class	During Construction Project	Upon Completion of Project
I	<ol style="list-style-type: none"> Execute work using methods to minimize raising dust from construction operations. Immediately replace a ceiling tile displaced for visual inspection. 	<ul style="list-style-type: none"> Contractors will conduct cleaning with approved disinfectant.
II	<ol style="list-style-type: none"> Provide enclosure to control dust migration using portable tent (control cubes) or sheetrock, plywood, plastic (6 mil poly) to seal area from non-work area with a HEPA vacuum continuously running to create negative pressure (Monitoring airflow direction is not required). Provide active means as described below to prevent airborne dust from dispersing: <ul style="list-style-type: none"> Water mist work surfaces to control dust while cutting. Seal unused doors with tape if high risk site adjacent to construction site. Place sticky mat at entrance and exit of work area and change sticky mat when covered with dust. Provide dampen walk off mats at fixed location. If used must be kept damp. Contain construction debris (e.g. seal with plastic) prior to removal from site Use only designated route/elevator to transport materials or construction debris. 	<ul style="list-style-type: none"> Vacuum with HEPA filtered vacuum prior to removing barrier.

<p>III</p>	<ol style="list-style-type: none"> 1. Disconnect or isolate HVAC system in area in consultation with Engineering & Maintenance where work is being done to prevent contamination of duct system or adjacent spaces. 2. Complete all critical barriers i.e. sheetrock, plywood, plastic (6 mil poly), to seal area from non-work area, or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins. 3. Place dust mat at entrance and exit of work area and replace or clean when no longer effective. 4. Maintain negative air pressure (>0.01" water) within work site utilizing HEPA equipped air filtration units or other methods to maintain negative pressure. 5. Re-circulating HEPA units may supplement dust control measures inside the work area. 6. Additional HEPA filtration unit should be installed near all entrances and exits to the work area. 7. The contractor will inspect all dust control equipment daily and log the results. 8. Keep work area broom clean and remove debris daily. 9. Contain construction debris (e.g. seal with plastic) prior to removal from site 10. Use only designated route/elevator to transport. 	<ul style="list-style-type: none"> • Do not remove barriers from work area until completed project is inspected by Environmental Health and Safety. • Contractor to clean area with HEPA filtered vacuum or wet mop as appropriate to the satisfaction of the Project Manager. • Remove isolation of HVAC system in areas where work was being performed.
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IV	<ol style="list-style-type: none"> 1. Disconnect or isolate HVAC system in area in consultation with Engineering & Maintenance where work is being done to prevent contamination of duct system or adjacent spaces. 2. Complete all critical barriers i.e. sheetrock, plywood, plastic (6 mil poly), to seal area from non-work area, or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins. 3. Place dust mat at entrance and exit of work area and replace or clean when no longer effective. 4. Maintain negative air pressure (>0.01" water) within work site utilizing HEPA equipped air filtration units or other methods to maintain negative pressure. 5. Re-circulating HEPA units may supplement dust control measures inside the work area. 6. Additional HEPA filtration unit should be installed near all entrances and exits to the work area if appropriate. 7. The contractor will inspect all dust control equipment daily and log the results. 8. Keep work area broom clean and remove debris daily. 9. Contain construction debris (e.g. seal with plastic) prior to removal from site 10. Seal holes, pipes, conduits, and punctures appropriately. 11. Construct anteroom and require all personnel to pass through this room. Wet mop or HEPA vacuum the anteroom daily. 12. During demolition, dust producing work, or work in the ceiling, disposable shoe covers and coveralls are to be worn and removed in the anteroom when leaving the work area. 13. Use only designated route to transport materials or construction debris. 	<ul style="list-style-type: none"> • Do not remove barriers from work area until completed project is inspected by Plant operations • Contractor to clean area with HEPA filtered vacuum or wet mop as appropriate to the satisfaction of the Project Manager. • Remove isolation of HVAC system in areas where work was being performed. • Housekeeping Service will conduct cleaning with approved disinfectant before re-occupation of the area.
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Step 5: Life Safety Assessment

Life Safety Assessment	Answer (Yes, No)	Alternative Measures If "YES" is answered for any questions in the life safety assessment, alternative life safety measures must be indicated
1. Will any existing required path of egress be obstructed or impacted by planned work or construction?	yes	The newly identified path of egress has been posted and staff educated. Fire drills will be completed weekly on each shift. Exit signs temporarily removed.
2. Will any existing exit signs need to be covered; removed or relocated?	yes	This has been accomplished
3. Will new exit signage be required due to rerouting of a path or egress?	yes	New signage has been placed.
4. Will fire suppression system (wet/dry/pre-action sprinklers) be impaired during any part of planned work or construction?	no	
5. Will any component of a fire alarm system be impaired during any part of planned work or construction?	yes	Smoke detectors disabled. See plan
6. Will any existing fire/smoke rated separation be impacted by planned work or construction?	no	
7. Will existing fire extinguishers be removed from the space during planned work or construction?	no	

Step 6: Sign-Off:

Project Team/Hiring Department Supervisor must complete this form to document the results of the assessment of the planned work/construction project.

PROJECT NAME/DESCRIPTION: _____

Construction Project Type (A-D): _____

Risk Group Classification (Low-Medium-High): _____

Risk Mitigation Measures Class (I – IV): _____

Have any life safety issues been identified through the Life Safety Assessment? ____ Yes ____ No

The Project Team / Hiring Department Supervisor must submit a written plan detailing how dust/fume control and Interim Life Safety Measures (ILSM) if required, will be achieved to the CEO for any work:

1. That requires Class II, III, or IV risk mitigation measures, and/or
2. That requires interim life safety measures

Work cannot commence until the plan is approved by both CEO and the Project Manager.

Sign-Off:

Project Manager/Supervisor: _____ Date:

CEO: _____ Date:

Dust Control Plan and Interim Life Safety Measures

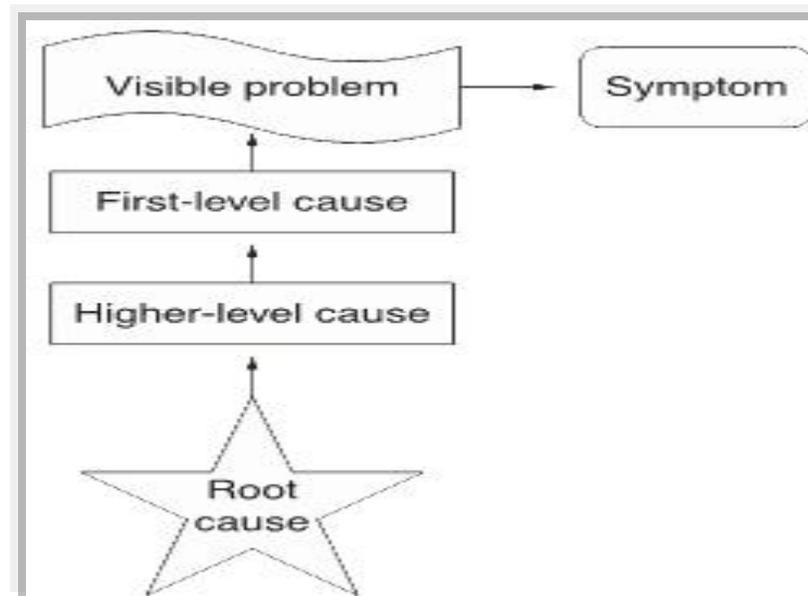
Dust Control:

Interim Life Safety

Appendix G

ROOT CAUSE ANALYSIS

The highest-level cause of a problem is called the root cause:



The root cause is “the evil at the bottom” that sets in motion the entire cause-and-effect chain causing the problem(s) and or adverse outcome.

Some root cause analysis approaches are geared more toward identifying true root causes than others; some are more general problem-solving techniques, while others simply offer support for the core activity of root cause

At the start of your fact finding team meeting list the sequence of events (flowchart) as they happened that lead to the problem, issues, or Sentinel Event.

If there is a defined procedure for the process that resulted in an adverse outcome list the sequence of steps in the approved procedure.

Compare the actual sequence of events to the steps outlined in the procedure. Identify any areas in the event sequence where approved procedure was not followed.

These areas may become the basis to develop a Cause and Effect Diagram to identify Root Cause.

Root causes analysis using the Cause and Effect methods.

What's the Problem?



Define the issue by its impact to overall goals. People often disagree over how to define the problem. You can get alignment when the problem is defined by the impact to the goals.

Why did it happen?



Break the problem down into a visual map. Using a Cause and Effect Diagram to provide a thorough explanation revealing all of the causes required to produce the problem.

What will be done?



Prevent or mitigate any negative impact to the goals by selecting the best solutions. Effective solutions should make a change to how people execute work process.

Better Communication, Better Analysis



The Sequence of Events identifies areas needing more investigation.

The Cause and Effect Diagram creates a visual dialogue, making it easier to communicate what's known and what needs a little more digging.

People can see how all of the pieces fit together to produce a particular incident.

The better an organization gets at explaining its problems, the better it becomes at finding smart solutions.

How to Use the Cause and Effect (Fishbone) Tool for Root Cause Analysis

Overview:

Root cause analysis is a structured team process that assists in identifying underlying factors or causes of an adverse event or near-miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain the correction.

A cause and effect diagram, often called a “fishbone” diagram, can help in brainstorming to identify possible causes of a problem and in sorting ideas into useful categories. A fishbone diagram is a visual way to look at cause and effect. It is a more structured approach than some other tools available for brainstorming causes of a problem (e.g., the Five Whys tool). The problem or effect is displayed at the head or mouth of the fish. Possible contributing causes are listed on the smaller “bones” under various cause categories. A fishbone diagram can be helpful in identifying possible causes for a problem that might not otherwise be considered by directing the team to look at the categories and think of alternative causes. Include team members who have personal knowledge of the processes and systems involved in the problem or event to be investigated.

Directions:

The team using the fishbone diagram tool should carry out the steps listed below.

- Agree on the problem statement (also referred to as the effect). This is written at the mouth of the “fish.” Be as clear and specific as you can about the problem. Beware of defining the problem in terms of a solution (e.g., we need more of something).
- Agree on the major categories of causes of the problem (written as branches from the main arrow). Major categories often include: equipment or supply factors, environmental factors, rules/policy/procedure factors, and people/staff factors.
- Brainstorm all the possible causes of the problem. Ask “Why does this happen?” As each idea is given, the facilitator writes the causal factor as a branch from the appropriate category (places it on the fishbone diagram). Causes can be written in several places if they relate to several categories.
- Again asks “Why does this happen?” about each cause. Write sub-causes branching off the cause branches.
- Continues to ask “Why?” and generate deeper levels of causes and continue organizing them under related causes or categories. This will help you to identify and then address root causes to prevent future problems.

Tips:

- Use the fishbone diagram tool to keep the team focused on the causes of the problem, rather than the symptoms.
- Consider drawing your fish on a flip chart or large dry erase board.
- Make sure to leave enough space between the major categories on the diagram so that you can add minor detailed causes later.
- When you are brainstorming causes, consider having team members write each cause on sticky notes, going around the group asking each person for one cause. Continue going through the rounds, getting more causes, until all ideas are exhausted.

- Encourage each person to participate in the brainstorming activity and to voice their own opinions.
- Note that the “five-whys” technique is often used in conjunction with the fishbone diagram – keep asking why until you get to the root cause.
- To help identify the root causes from all the ideas generated, consider a multi-voting technique such as having each team member identify the top three root causes. Ask each team member to place three tally marks or colored sticky dots on the fishbone next to what they believe are the root causes that could potentially be addressed.

Examples:

Here is an example of the start of a fishbone diagram that shows sample categories to consider, along with some sample causes.

Here is an example of a completed fishbone diagram, showing information entered for each of the four categories agreed upon by this team. Note, as each category is explored, teams may not always identify problems in each of the categories.

Facts gathered during preliminary investigation:

- Time of fall: change of shift from days to evenings
- Location of fall: resident’s bathroom
- Witnesses: resident and aide
- Background: the plan of care stipulated that the resident was to be transferred with two staff members, or with one staff member using a sit-to-stand lift.
- Information from interviews: the resident was anxious and needing to use the bathroom urgently. The aide was helping the resident transfer from her wheelchair to the toilet, without using a lift, and the resident fell, sustaining an injury. The aide stated she did not use the lift because the battery was being recharged, and there was no extra battery available. The aide stated she understood that the resident could be transferred with assist of one.

With this information, the team proceeded to use the fishbone diagram to better understand the causes of the event.

The value of using the fishbone diagram is to dig deeper, to go beyond the initial incident report, to better understand what in the organization’s systems and processes are causing the problem, so they can be addressed.

In this example, the root causes of the fall are:

- There is no process in place to ensure that every lift in the building always has a working battery. (One battery for the lift on this unit is no longer working, and the other battery was being recharged.)
- There is no process in place to ensure timely communication of new care information to the aides. (New transfer information had not yet been conveyed to the aide. The aide’s “care card” still indicated transfer with assist of one for this resident.)

The root causes of the event are the underlying process and system problems that allowed the contributing factors to culminate in a harmful event. As this example illustrates, there can be more than one root cause. Once you have identified root causes and contributing factors, you will then need to address each root cause and contributing factor as appropriate.

➤ **Root Causes are Identified**

➤ **Develop Action Plan for each Root Cause.**

➤ **Identify a Goal for each Root Cause.**

➤ **List the Steps needed to accomplish the Goal.**

➤ **What Resources are needed to complete the action steps?**

➤ **Who is Responsible for the Goal's steps?**

➤ **What is the anticipated Timeframe for completion?**

➤ **How will you Measure the effectiveness of the action steps?**

Planning is preparatory to action. Analytically at least, planning must be separated from implementation so that the major policy decisions can be taken and their implications understood prior to action

8 Steps to Develop a Plan for Action

1 Express your solution as a series of goals

Having agreed on a root cause to a particular problem within your organization, you first need to define that solution in terms of a goal. For example, each goal could be expressed as follows: "For us to, we would need to" Record each goal at the top of a whiteboard or sheet of paper

2 Generate a list of Actions for each goal

Use brainstorming to compile a list of actions to achieve a particular goal and record these below the goal. Arrange this list of suggested actions in sequential order. Include training and education, P&P changes, approvals.

3 Prepare a timeline

Beginning with a time point labeled "now" and ending with a point labeled "goal achieved", build a timeline on which you allocate dates by which you intend to complete each of the sequential actions listed under a particular goal. It is important that you get both sequence and timing right if you are to reach "goal achieved" effectively.

4 Allocate resources

Financial, physical and human resources must be allocated to each action step. If resources are limited, or fall short of requirements at any stage, it may be necessary to return to an earlier step and revise the action plan.

5 Identify possible problems

Consider all of the things that could go wrong in the process of achieving a particular goal. List these problems and identify causes and suitable actions to resolve them. If necessary, these actions might need to be added to appropriate slots in the timeline

6 Develop strategies for monitoring progress

List ways in which progress of the action plan can be monitored. These monitoring stages should also be included on the timeline.

7 Assign tasks

Take each point on the timeline in turn and ask : "Who will do what, by the date set, to bring about the specified action? Allocate these tasks to appropriate individuals or teams.

8 Implement the plan

Translate all your information to a clean copy, listing the actions required, the person responsible for a particular task, and when that task is to be completed. Having now finalized the plan for action in specific terms, this information can now be made available to all involved.

Corrective Action Plan

Root Cause:

Goal:

Potential Obstacles:

Action Steps	Required Resources	Projected timeframes	Responsible
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Corrective Action Plan

Root Cause:

Goal:

Potential Obstacles:

Action Steps	Required Resources	Projected timeframes	
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Executive Summary Report

Brief incident description:

Incident date:

Incident type:

Actual effect on patient and/or service:

Actual severity of incident:

Level of investigation conducted

Involvement and support of the patient and/or relatives

Detection of the incident

Care and service delivery problems

Contributory factors

Root causes

Lessons learned
Recommendations
Arrangements for sharing learning
Outcome of Measurement

Name

Title

Date

Root Cause Analysis Investigation Report

Incident Investigation Title:	
Incident Date:	

Incident Number:	
Author(s) and Job Titles	
Investigation Report Date:	

Executive Summary Report

Brief incident description:

Incident date:

Incident type:

Actual effect on patient and/or service:

Actual severity of incident:

Level of investigation conducted

Involvement and support of the patient and/or relatives

Detection of the incident

Care and service delivery problems

Contributory factors

Root causes

Lessons learned

Recommendations

Arrangements for sharing learning

Outcome of Measurement

Name

Title

Date

Sentinel Event Investigation

Purpose To identify the root causes and key learning from an incident and use this information to significantly reduce the likelihood of future harm to patients
Objectives <ul style="list-style-type: none">• To establish the facts i.e. what happened (<i>effect</i>), to whom, when, where, how and why (<i>root causes</i>)• To establish whether failings occurred in care or treatment• To look for improvements rather than to apportion blame• To establish how recurrence may be reduced or eliminated• To formulate <i>recommendations and an action plan</i>• To provide a <i>report and record</i> of the investigation process & outcome• To provide a means of <i>sharing learning</i> from the incident• To identify routes of <i>sharing learning</i> from the incident
Key questions/issues to be addressed <ul style="list-style-type: none">• ...specific to this incident or incident type
Key Deliverables <ul style="list-style-type: none">• Investigation• Report,• Action Plan,• Implementation of Actions
Scope (investigation start & end points)
Investigation type, process and methods used <ul style="list-style-type: none">• Single or Multi-incident investigation• Gathering information e.g. <i>Interviews</i>• Incident Mapping e.g. <i>Tabular timeline</i>• Identifying Care and service delivery problems e.g. <i>Change analysis</i>• Identifying contributory factors & root causes e.g. <i>Fishbone diagrams</i>• Generating solutions e.g. <i>Barrier analysis</i>
Arrangements for communication, monitoring, evaluation and action
Investigation team Names, Roles, Qualifications, Departments
Resources
Involvement of other organizations
Stakeholders/audience
Investigation timescales/schedule

Level of investigation

Add text here

Involvement and support of patient and relatives

Add text here

Involvement and support provided for staff involved

Add text here

Information and evidence gathered

Add text here

CONCLUSIONS:

Recommendations

Add text here

Arrangements for Shared Learning

Add text here

Distribution List

Add text here

Appendices

Add text here

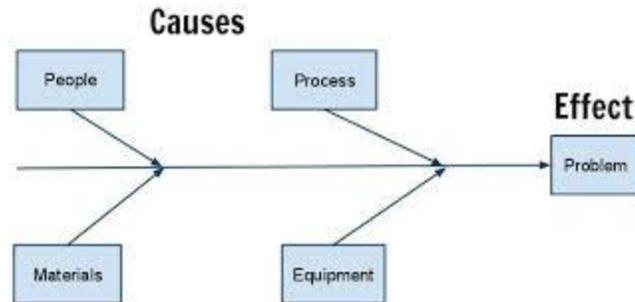
Data Collection

Measure of Success Indicators	How data collected	By Whom	Timeframe	Follow up

APPENDIX H

FISHBONE DIAGRAM

The Cause and Effect Diagram is used to explore all real, possible and potential causes of the single effect/outcome you are now experiencing.



Creating a cause and effect diagram is fun and educational. These diagrams are usually constructed as a team or group activity to get ideas from as many people as possible. As a result of everyone working on the diagram together, everyone tends to gain some new knowledge. Cause and effect diagrams encourage new ideas about causes of problems by helping the group think about different categories of causes. The cause and effect diagram also indicates how much we know about our process. If the diagram is full, we know a lot about our process. If it is sketchy, chances are we don't have a good understanding of our process. Cause and effect diagrams should be living documents. That is, we should actively seek causes of problems and add to the diagram as time goes on.

A cause and effect diagram is a tool that shows the relationship between an effect and possible sources of variation for this effect (causes). As shown in the figure the effect could be a problem that needs to be solved. The causes of the problem would then be listed on the cause and effect diagram. The effect could also be a goal. In this case, what needs to be done to reach the goal would be listed on the cause and effect diagram.

The causes are most commonly categorized as machines, methods, environment, materials, measurement, and people (the 4 M's, a P and an E). This is particularly true for manufacturing applications. You can pick your own categories. See above for 4 categories that may be used in healthcare. (People, Process, Materials, Equipment)

Cause and effect diagrams are also called fishbone diagrams (because of their appearance) and Ishikawa diagrams (because of their developer). Cause and effect diagrams can be used for any problem in any area

The cause and effect diagram is one of many root cause analysis tools. Root cause analysis should be thorough enough to "root" out the deep and hidden causes that are often missed with quick fixes to problems. It provides a method of taking all the jumbled-up ideas we have and arranging them so we can use a systematic approach to improvement.

How to Construct a Fishbone Diagram

1. Pinpoint the problem you want to fix or the goal you want to reach.
2. Write the problem or goal (effect) on the right hand side of a large sheet of paper taped to the wall and draw a horizontal line to the left.
3. Select the categories for the causes of the problem or for what needs to be done to reach the goal. These categories will be the main factors of the cause and effect diagram. Each main factor forms a branch off the horizontal line.
4. Brainstorm detailed causes for each main factor. These detailed causes are written on branches off those of the main factors. Use the brainstorming rules shown below to maximize the number of causes your group develops.
 - Go for quantity of ideas.
 - Everyone participates.
 - Encourage creativity.
 - Don't discuss/criticize/evaluate ideas.
 - Build off other ideas.
 - Pass if you don't have an idea to contribute.
5. Always try to branch further by continuously asking, "What causes variation in this branch?" In this way, you can add to the cause and effect diagram until it fully shows all the possible causes of variation.

A summary of the general rules for constructing a cause and effect diagram is given below.

1. Get everyone to participate.
2. Don't forget that this is a brainstorming session; brainstorming rules apply.
3. Give ideas one at a time to encourage creative ideas.
4. Have the person giving the idea tell which "bone" of the fish the idea goes on. For example, say "My idea is the truck tire pressure. That goes on the Materials bone."
5. Allow any idea to go on more than one bone. Allow other team members to use the same idea on multiple bones.

6. Never analyze or criticize suggestions while creating the fishbone. This includes nonverbal criticism such as shaking your head or drawing back from the group.
7. Piggyback one suggestion into another, let ideas suggest other ideas.
8. Use the major bones to help you come up with ideas. For example, think to yourself, "How could our methods or procedures cause this problem?"
9. Ask yourself for each idea that has already been given, "Why does that happen? How does that happen?" to develop branches or "smaller bones" off each major bone.
10. Be open and honest. Have the courage to give the idea that everyone is thinking about, but doesn't want to state.
11. Never use the suggestion that someone came up with in a fishbone session against the person outside the meeting. For example, never leave the meeting saying, "You'll never guess what Sam thought the problem was...He thinks that it's all Harvey's fault!"

Appendix I

LINK TO SENTINEL EVENT REGISTRY TOOLKIT.
Use Control /enter while holding cursor over title
below.

Access to the complete manual for using the
registry and Redcap.

[The Sentinel Event Registry Toolkit](#)

 North Vista Hospital DEPARTMENTAL POLICIES AND PROCEDURES		Page(s):	Page 1 of 19
		Saved As:	Patent Safety Plan 2018
Subject:	Patient Safety Plan 2019	Formulated:	Prime-2009
Manual:	ADMINISTRATIVE MANUAL	Reviewed:	02/19
GOVERNING BOARD APPROVAL	Date:	Revised:	02/19

INTRODUCTION

North Vista Hospital is committed to providing quality healthcare to all patients. The Patient Safety Plan serves as a framework to establish and maintain a safe patient care environment. It expands the organization -wide support for risk management, performance improvement, information management, education, human resources and patient’s rights by implementing patient safety standards, measuring and monitoring their effectiveness, and creating a “culture of safety” as part of the overall quality program.

PURPOSE

1. Our goal is to establish a proactive approach to prevent patient injuries and other medical errors in an open and non-punitive environment. The Patient Safety Plan is to assure that a planned, systematic, coordinated approach exists to improve patient safety and reduce risk to patients through an environment that includes.
 - 1.1 Integration of all patient-safety activities both existing and newly created
 - 1.2 Identifies focus of accountability and support within the leadership of the organization
 - 1.3 Involves patients, their families, staff and leaders in the identification and management of actual and potential risks to patient safety as well as opinions, needs and perceptions of risks to patients and suggestions for improving patient safety
 - 1.4 Recognizes acknowledgment of risks to patient safety and medical / healthcare errors
 - 1.5 Initiates actions to reduce these risks
 - 1.6 Internally reports of what has been found and the actions taken
 - 1.7 Focuses on processes and systems rather than individual blame and retribution
 - 1.8 Ongoing proactive reduction in medical / healthcare errors
 - 1.9 Considers patient safety priorities in the design and redesign of all relevant organization processes, functions and services
 - 1.10 Communicates to patients and when appropriate to their families about the outcomes of care, including unanticipated outcomes
 - 1.11 Educates patients and families about their role in helping to facilitate the safe delivery of care
 - 1.12 Ongoing orientation, in-service and other education and training programs to emphasize specific job-related aspects of patient safety to maintain and improve staff competence.

2. The Patient Safety Plan involves all departments and disciplines at all levels of Hospital in establishing the processes and mechanisms that comprise the patient safety activities

through the recognition and acknowledgment of risks, preventive actions to reduce risk, internal reporting and corrective actions taken and fostering a non-punitive environment when errors occurs.

3. Proactive identification and management of potential risks to patient safety have the obvious advantage of *preventing* adverse occurrences, rather than simply *reacting* when they occur. This approach also avoids the barriers to understanding created by hindsight bias and the fear of disclosure, embarrassment, blame, and punishment that can arise in the wake of an actual event.

SCOPE OF ACTIVITIES

1. Hospital recognizes that patients, staff and visitors have the right to a safe environment. Therefore, the organization commits to undertaking a proactive approach to the identification and mitigation of medical errors through the integration into and participation of all components of the hospital into the hospital wide program. This includes Performance Improvement, Risk, Infection Control and EOC programs.
2. The Patient Safety Plan promotes the use of internal and external knowledge and experience to identify, analyze, and prevent the occurrence of medical / healthcare errors and identify areas of opportunity to maintain and improve patient safety.
3. Patient safety information will be analyzed from aggregated data reports and summarized in the Patient Safety Dashboard. These reports will be reported to appropriate hospital and Medical Staff committees and to the Governing Board. The aggregate data will be used to prioritize organization-wide patient safety efforts.
4. The organization also recognizes that despite our best efforts, errors can and will occur. Therefore, it is the intent of the organization to respond quickly, effectively, and appropriately when an error does occur.
5. The organization also recognizes that the patient has the right to be informed of the results of treatment or procedures whenever those results differ significantly from anticipated results.

DEFINITIONS

Error

An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

A failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems.

Patient Safety

The degree to which the risk of an intervention and risk in the care environment are reduced for a patient while under the treatment of a healthcare provider or facility.

Patient Safety Event	Any identified defect, error, medical accident, near miss, sentinel event, medication error, significant procedural variance, or other threat to safety that could result in patient injury.
Medical Accident (Error)	An unintended event in the system of care with actual or potentially negative consequences to the patient. Types of medical errors: <ul style="list-style-type: none"> ▪ Diagnostic errors (misdiagnoses leading to an incorrect choice of therapy or treatment, failure to use an indicated diagnostic test, misinterpretation of test results, failure to properly act on abnormal test results) ▪ Equipment failures (defibrillator without working batteries, or inadvertent dosing of medications in a short time frame due to IV pumps with valves that are easily dislodged) ▪ Infections (HAI, post-op wound infections) ▪ Blood transfusion-related injuries ▪ Deaths due to seclusion / restraint use
Medical Accident, “near miss”	Any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. May include a clinical event.
Sentinel Event	An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would be a significant chance of serious adverse outcome.
Root Cause Analysis	A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.
Intensified Analysis	An examination of factors or elements that contribute to undesirable trends in performance to determine where best to focus changes for improvement.
Adverse Drug Event	A patient injury resulting from a medication, either because of a pharmacological reaction to a normal dose or because of a preventable adverse reaction to a drug resulting from an error.
Medication Error	Any preventable event that may cause or lead to inappropriate medication use or patient harm.
Hazardous condition	Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increased the likelihood of a serious adverse event.

AUTHORITY/ROLES & RESPONSIBILITY

1. Governing Board

- 1.1 The Hospital Governing Board has the ultimate authority and responsibility for approving the patient safety program. The Governing Board has delegated the responsibility of implementing an organization-wide patient safety program and creating a “culture of safety” to the leaders and medical staff of the hospital.

2. Administrator / CNO

2.1 The Administrator/CNO is responsible for assuring that this program is implemented, supported, and evaluated throughout the organization. As such, the Administrator/CNO will establish the structures and processes necessary to accomplish this objective. The Administrator/CNO may delegate the day to day implementation and evaluation of this program to an appropriate staff leader who can operationalize this plan such as the Patient Safety Officer who may be supported by the Director/Manager, Performance Improvement.

3. Director/Manager, Performance Improvement, Patient Safety Officer and Infection Control Officer

3.1 The Patient Safety Officer is the Risk Manager at North Vista Hospital. The Patient Safety Officer is responsible for the day to day implementation and evaluation of the processes and activities noted in this program. The Patient Safety Officer will work collaboratively with the Director/Manager of Performance Improvement and the Infection Control Officer in establishing the Patient Safety framework and a culture of patient safety. The leadership including Senior Administration and the Chief of Staff will provide support as needed to assure the Patient Safety Plan is fully implemented and effective in positively impacting patient safety issues.

3.2 Patient Safety Officer Duties Include (As indicated in [NRS 839.870](#)):

- a. Serve on the Patient Safety Committee (Chair of the Committee)
- b. Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing duties required pursuant to [NRS 439.835](#).
- c. Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility.
- d. Report to the patient safety committee regarding any action taken in accordance with number 3.2 c.

3.3 Other Duties shall include:

- a. Supports Patient Safety Committee by collecting and formulating relevant information to facilitate decision-making activities.
- b. Selects at least one high-risk patient safety process for proactive risk assessment (FMEA) at least every 12-18 months. Coordinates the process throughout this period.
- c. Presents Patient Safety reports to all departments.
- d. Develops, and recommends new policies and procedures for patient safety based on analysis of data from events, and other relevant information.
- e. Works in conjunction with the EOC Chair to prioritize risks, review and analyze data and performs risk analysis as needed to address the safety of the patient environment.
- f. Maintains the confidentiality and legal privilege, as appropriate, of all data and information.

- g. Facilitates patient safety orientation and in-service education programs.
- h. Measures and evaluates effectiveness of the patient safety program using the established goals and prepares an annual report for the Governing Board, which includes events related to staffing complement.
- i. Assists department directors and administrators in enforcing policies and procedures, standards of care.

4. Directors and Managers

- 4.1 The leaders of the organization maintain responsibility for proper collection and dissemination of information for continuing education pertaining to the Patient Safety Program to employees.
- 4.2 The leaders create an environment that encourages prompt error identification and reduction and minimizes blame or retribution against individuals involved in an error or the reporting of an error.
- 4.3 The leaders provide direction and resources to conduct proactive correction and reversal of conditions and procedures that increase the chance that a patient might be harmed.
- 4.4 The leaders will collaborate in decision making which effects the development of hospital-wide patient care programs; policies and procedures that describe how patient care needs are met.
- 4.5 The leaders will assist in the development and implementation of the Hospital Plan for the Provision of Care, Performance Improvement Plan, Risk Management Plan, Information Management Plan, decision-making structures and processes; and implementation of an effective and continuous program to measure, assess and improve performance and patient safety.

(Directors and Managers defined as those accountable for leadership, planning, organizing, developing, controlling, directing and evaluating care for designated departments – “Provision of Patient Care and Services”.)

5. Medical Staff

- 5.1 The Chief of Staff and Department Chairs of the organized medical staff through the Medical Executive Committee and in collaboration with the leaders of the organization promote and support the patient safety initiatives of Hospital. (Medical staff defined as those physicians who have been granted recognition as members of the medical staff pursuant to the terms of the Medical Staff Bylaws.)

6. Quality/Utilization Management Committee

- 6.1 Quality/Utilization Management Committee is assigned to oversee Patient Safety Committee at North Vista Hospital. Duties include:
 - a. Review Patient Safety Dashboard for trends, performance and improvement and make recommendations where necessary.
 - b. Review, provide input and recommend approval of Patient Safety Plans & evaluations where necessary.
 - c. Review all sentinel event / root cause analyses and intensified analyses if/as requested by Patient Safety Committee.

- d. Review risk assessments and FMEA and make recommendations where necessary.

7. Patient Safety Committee

- 7.1 The hospital has an organization-wide, integrated patient safety program which operates under the Patient Safety Committee. It is the responsibility of the Patient Safety Committee to implement a hospital-wide patient safety program. The Patient Safety Committee is chaired by the Patient Safety Officer (Risk Manager) who is tasked to manage the day to day operations of the patient safety program.
- 7.2 The scope of the patient safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events. All departments, programs, and services within the hospital participate in the patient safety program. As part of the patient safety program, the hospital creates procedures for responding to system or process failures.
- 7.3 Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#)):
 - a. Monitor and document the effectiveness of the patient identification policy.
 - b. On or before July 1st of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
 - c. Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
 - d. Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
 - e. At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - f. Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
 - The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter).
 - The number and severity of infections that occurred at the facility during the preceding calendar month or quarter.
 - Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
 - g. Provide regular reports to the Quality/Utilization Management Committee.
 - h. Implement and monitors the National Patient Safety Goals compliance within the facility.

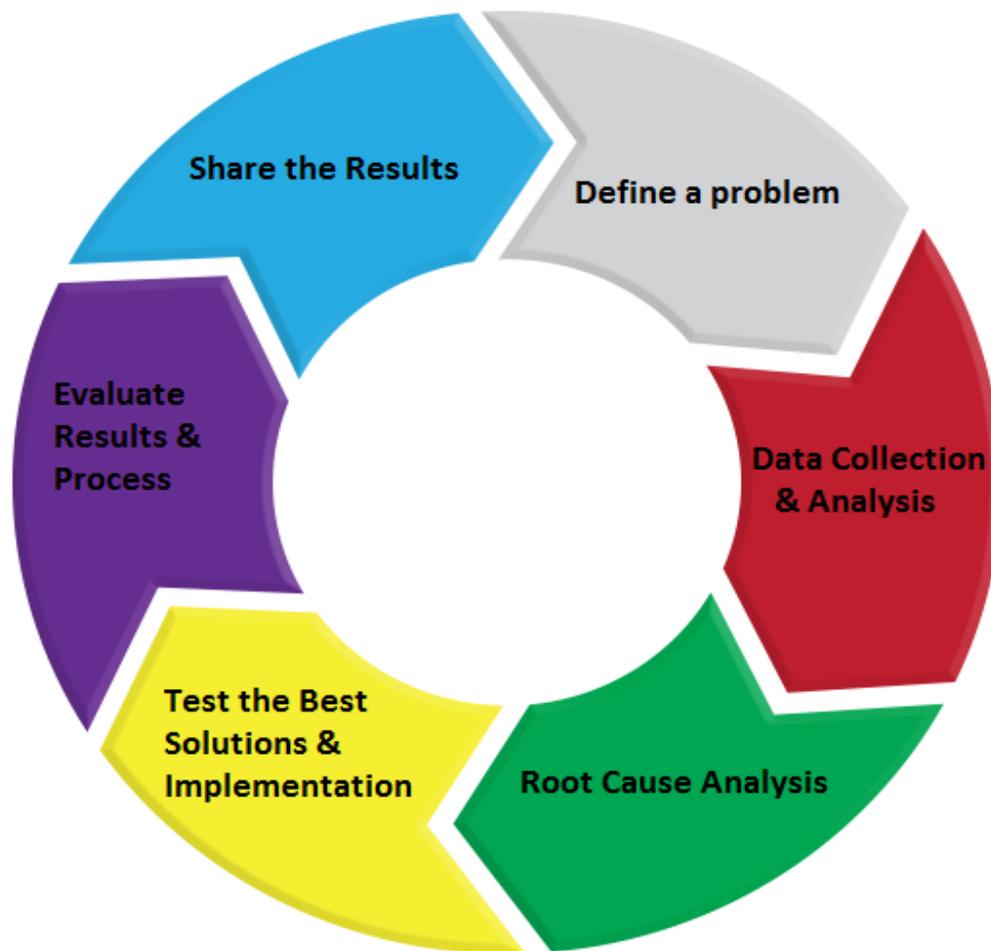
OBJECTIVES AND GOALS FOR THE PATIENT SAFETY PLAN

1. **Goal 1** – Improve the following 3 Patient Safety Culture Domains:
 - 1.1 Nonpunitive Response to Errors-2019 Goal: 20% (scored 2% in 2018)
 - 1.2 Communication Openness-2019 Goal: 55% (scored 49% in 2018)

- 1.3 Handoffs & Transitions-2019 Goal: 50% (scored 34% in 2018)
- 2. **Goal 2** – Reduce the number of patient falls in 2019 from 2018 (188 in 2018)
 - 2.2 Hospital Wide Performance Improvement Indicator (Risk Manager is lead) as listed in the Performance Improvement Plan
- 3. **Goal 3** – Reduce number of hospital acquired conditions (HACs) in 2019 from 2018
 - 3.1 2 CAUTIs, 2 CLABSI's, 12 C. Diff, & 0 SSI's

COMPONENTS AND METHODOLOGY

- 1. Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”
- 2. North Vista will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The FOCUS Plan-Do-Check-Act (PDCA) is the model which North Vista Hospital will use to test the changes.

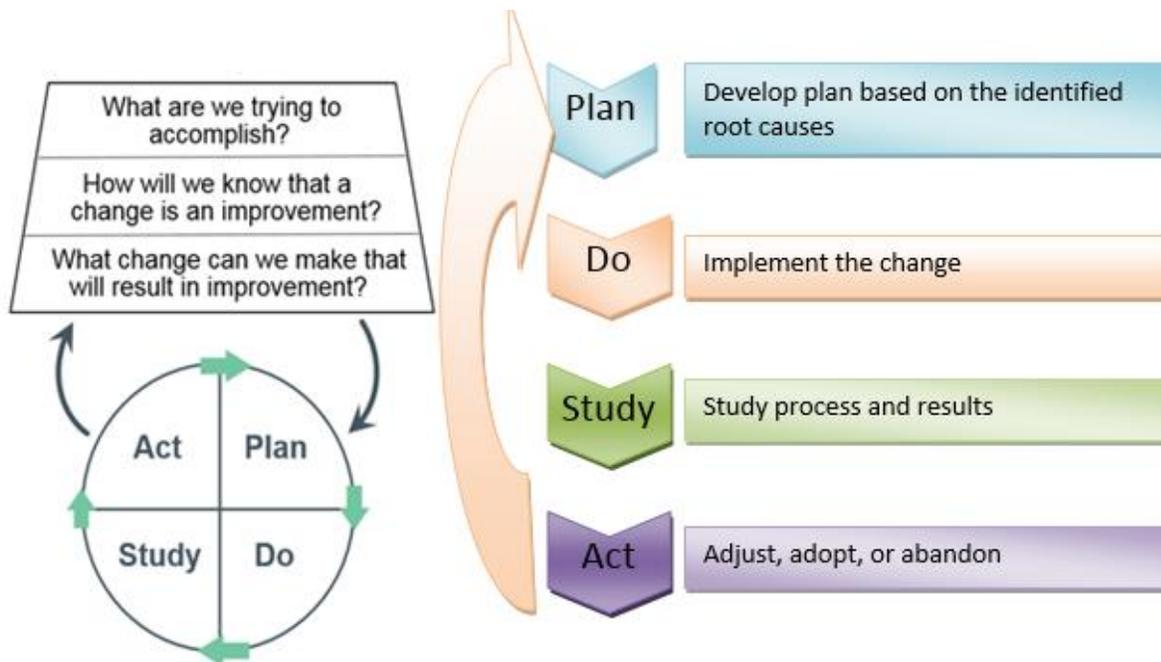


3. **Root Cause Analysis**

3.1 A Root Cause Analysis (RCA) is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis. The attached forms in Attachment I will be utilized to conduct RCAs.

4. **Model for Improvement**

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



4.2 This methodology will be accomplished utilizing the RCA forms attached in Attachment I. This methodology is also utilized in the Performance Improvement Plan to select Performance Improvement Indicators for each department.

DATA COLLECTION AND RISK ASSESSMENT

1. In order to reduce the likelihood of patient incidents and negative outcomes, North Vista Hospital will track the frequency and type of patient safety issues and compile them in order to learn from and prevent future negative occurrences. Examples of how the hospital collects and analyzes data is listed below.

1.1 Data Sources

a. Internal

- Risk incident reports with database compilation

- Adverse Drug Events and Adverse Drug Reactions
 - Data from patient complaints
 - Risk Management and Safety findings
 - Compliance findings
 - PI and special study findings
 - Infectious Disease information
 - Operative/Invasive procedures
 - Departmental indicators
 - Employee surveys (includes perception of risk)
- b. External
- Core Measures Indicators
 - Accreditation/regulatory deficiencies
 - Patient Satisfaction Surveys
 - Other Evidence-Based external sources
- 1.2 Risk Assessment (Failure Mode and Effect Analysis)
An assessment that examines a process in detail including sequencing of events; assesses actual and potential risk, failure, points of vulnerability; and through a logical process, priorities areas for improvement based on the actual or potential patient care impact (criticality).
- 1.3 Data Analysis
Analysis of collected data will be undertaken to monitor and identify levels of performance, trends or patterns that vary significantly from expected outcomes and the need for possible change/improvement in systems or processes.
- 1.4 Process Improvement
When undesirable outcomes are identified, the hospital shall involve the personnel, resources, disciplines, and department/services most directly involved with the process to reduce future risk.
- 1.5 FOCUS PDCA (Plan, Do, Check, Act) methodology for Performance Improvement will be utilized for all performance improvement activities within the facility. This methodology will not be used when conducting RCAs

PATIENT SAFETY CHECKLISTS & PATIENT SAFETY POLICIES

1. By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:
- 1.1 Providers of healthcare who provide treatment to patients at the facility;
 - 1.2 Other personnel of the facility who provide treatment or assistance to patients;
 - 1.3 Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
 - 1.4 Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- 1.5 Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- 1.6 Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- 1.7 A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - a. Proper instructions concerning prescription medications;
 - b. Instructions concerning aftercare;
 - c. Any other instructions concerning his or her care upon discharge; and
 - d. Any other checklists which may be appropriate to ensure the safety of patients at the facility.
- 1.8 The patient safety policies must include, without limitation:
 - a. A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
 - b. A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
 - c. A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

CULTURE OF SAFETY SURVEY

1. North Vista Hospital will utilize the Agency of Healthcare and Research Quality (AHRQ) research survey that is intended to measure the ten dimensions of culture pertaining to patient safety:
 - 1.1 Supervisor/manager expectations & actions promoting patient safety
 - 1.2 Organizational learning – continuous improvement
 - 1.3 Teamwork within units
 - 1.4 Communication openness
 - 1.5 Feedback & communications about errors
 - 1.6 Non-punitive response to error
 - 1.7 Staffing effectiveness
 - 1.8 Hospital management support for patient safety
 - 1.9 Teamwork across hospital units
 - 1.10 Hospital handoffs & transitions

The results of the survey will be used by the Patient Safety Committee to enhance the patient safety program at North Vista Hospital.

CONFIDENTIALITY

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in [NRS 49.265](#)

PLAN EVALUATION

1. According to [NRS.439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan. The patient safety plan must be reviewed and updated annually in accordance with the requirements set forth in this section. According to NRS 439.843, on or before March 1st of each year, a copy of the most current patient safety plan (developed according to [NRS 439.865](#)) must be submitted to the Division of Public and behavioral Health.
2. This plan encompasses many disciplines and activities in addition to those specifically referenced in the plan. The Patient Safety Plan is designed to assist in the integration of these activities, not replace them. Integration should enhance the accountability and impact of the patient safety related activities and collectively provide a comprehensive quality management system for North Vista Hospital.
3. The Patient Safety Plan should be considered a "working" document and an interim product to facilitate the development of a "culture of safety". As such, the plan may be modified as the implementation of the patient safety standards takes place and sections of the plan are incorporated into existing plans, policies, procedures and protocols.
4. The Patient Safety Plan will be reviewed on an annual basis. Goals shall be identified and prioritized based on internal occurrences and trends, RCA, FMEA, survey results, sentinel events, State and Federal regulations, and other applicable patient safety issues and initiatives.

REFERENCES

Performance Improvement Plan

Infection Prevention and Control Plan

Environment of Care Plan

Plan for Provision and Patient Care Services

Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Approvals

Director / Manager Performance Improvement

Date

Chief Nursing Officer / Administrator

Date

Chief Executive Officer

Date

Chairman, PI Committee

Date

Chief of Staff

Date

Governing Board

Date

DETERMINATION OF SEVERITY

Hospital Name:	Date Identified:
-----------------------	-------------------------

When Did the Event Occur?		
Date:	Day of the week:	Time:
Diagnosis:		

What Type of Incident is this? (See below for definitions)		
<input type="checkbox"/> Error	<input type="checkbox"/> Near Miss / Hazardous Condition	<input type="checkbox"/> Sentinel Event
Explain Error Type (based on definitions below):		

Identified How/Reported by Whom:	Staff Witnesses:

Who were the direct/indirect caregivers involved in the event? (use no personal identifiers, job titles only)

Brief Description (No names or other individual identifiers):

Definitions:

Error:

An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

Sentinel Event:

An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Near Miss:

Used to describe any process variation that did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of sentinel event, but outside the scope of those sentinel events that are subject to review by the Joint Commission under its sentinel event policy. Refer to the Sentinel Event Policy for JCAHO reviewable events.

Hazardous Condition:

Any set of circumstances (exclusive of the disease or condition for which the patient is being treated), which significantly increases the likelihood of a serious adverse outcome.

ORGANIZATION OF THE TEAM

Team Leader:	Team Meeting Date:
	Date RCA / IA Completed:

Team Members:	Job Title:

Documents/Policies Gathered (include Timeline, Flowchart, etc.):	

UNDERSTAND THE CURRENT PROCESS
<p>What was intended to happen, normally occur? (steps as defined by the policy, procedure)</p>
<p>What went wrong? (Easily identifiable, proximal causes) (Were there any steps in the process that did not occur as intended?)</p>

ROOT CAUSE ANALYSIS

(Checkoff the appropriate sections. This is the **ANALYSIS** section where you document the drill down of the event. Remove items rows not applicable)

Process	Analysis
<input type="checkbox"/> Behavioral Assessment Process: Was patient's mood/ behavior approp assessed upon admission? Were potential mood/behavior problems identified approp/subsequently monitored? Were referrals made to physicians, Social Work, or Behavioral Health? Are current assmt. tools approp. measurement of mood/behavior?	
<input type="checkbox"/> Physical Assessment Process: Was patient approp. assessed upon admission or prior to their procedure? Was the patient approp. re-assessed throughout their stay? Were assessments done timely and according to policy? If conditions identified, did staff act approp. follow up, referrals, etc.?	
<input type="checkbox"/> Patient Identification Process: Was the patient approp. identified by an ID band or by other means? Are there deficits in the patient identification process that permitted the error to occur? Did the patient have approp. patient identifiers in place (i.e. ID bands, chart labels, etc.)?	
<input type="checkbox"/> Patient Observation Procedures: Was the patient approp. observed/monitored during their stay/procedure? Were conditions present that warranted increased observation/monitoring that were not identified by staff?	
<input type="checkbox"/> Care Planning Process: Was the patient's care planned approp.? Did the patient have a completed History and Physical? Was care deemed to be appropriate as planned? Was the outcome a complication despite appropriate care planning?	
<input type="checkbox"/> Continuum of Care: Was the outcome affected by a breakdown in the continuum of care? Was there a failure to provide adequate information/services from a prior caregiver or other discipline that contributed to the event? Were the appropriate referrals made according to the patient's assessment? Were the appropriate referrals completed?	
<input type="checkbox"/> Staffing Levels: Are staffing levels high enough to meet demand; limitations overtime? Agency/float staff in use? Are staff members approp. matched to assignments? How many continuous hours had the staff/physician involved been working?	
<input type="checkbox"/> Orientation and Training Of Staff: Is ongoing training available regarding the process involved in the event? Are employees oriented to the process involved in the incident? Are staff members aware of reference resources? If event involved a contingent or agency staff member, was orientation and training sufficient for the delivery of patient care?	
<input type="checkbox"/> Competency Assessment/Credentialing: Have staff completed orientation and training on the process involved? Is assessment of employee performance of this procedure part of the employee review process? When was last competency assessment completed? Need to repeat them? What the process involved a "core ability" of the staff member, if so, should competencies be considered? Include omissions in critical thinking and/or performance variance(s) from defined policy, procedure, protocol and guidelines in effect at time.	

<input type="checkbox"/> Supervision of Staff: Are supervisors readily available to both experienced and new staff? Are performance standards made clear? Are staff members observed in the performance of their daily work? Would direct supervision have resulted in a better outcome in this process?	
<input type="checkbox"/> Communication with Patient/Family: Was communication with the patient hindered in any fashion (i.e. a comatose or demented patient)? Was the family or significant other present to assist with the assessment process? Is the patient a reliable historian?	
Process	Analysis
<input type="checkbox"/> Communication Among Staff Members: Are instructions clear and precise: evaluation of verbal, written, electronic communication or the lack thereof? Timing factor? Handoff? Are human interactions free of intimidation and embarrassment? Was key information communicated from one caregiver to another as appropriate? Were appropriate referrals made?	
<input type="checkbox"/> Availability of Information: To what degree was all the necessary information available when needed? Accurate? Complete? Unambiguous? Does historical information include all pertinent information needed to facilitate care of the patient? Was the sharing of necessary information hindered due to technological reasons?	
<input type="checkbox"/> Adequacy of Technological Support: Did automation actually contribute to this event? Is the right equipment used for the task at hand? Is the equipment up-to-date? Are resources available to answer the operator's questions about the equipment? Does equipment design play a role in causing problems?	
<input type="checkbox"/> Equipment Maintenance/Management: Is machinery/equipment working properly? Are service guidelines being followed? Is backup equipment on hand? Biomed checks done?	
<input type="checkbox"/> Physical Environment: Current environment meets code? Do noise levels make it difficult for staff to communicate? Was there an environmental risk involved in the event that was not previously identified? Was location a factor in causing the event? Was the facility on any special status at the time (e.g. fire drill, Code Blue, etc.)? Lighting issues?	
<input type="checkbox"/> Security Systems and Processes: Were medications/equipment/supplies needed for the delivery of care secured properly? Were medications/equipment/supplies needed for the delivery of care able to be obtained. Was the safety and security of the patient/staff adequate? Were there deficits or breaches in security that contributed to the event?	
<input type="checkbox"/> Control of Medications - Storage/Access: Are medications stored properly? For example, are dangerous drugs stored away from patient-care units? Is storage set up to eliminate confusion? Is access to medications limited to the appropriate personnel?	
<input type="checkbox"/> Labeling of Medications: Are labels clear and legible? Do similarities in packaging cause confusion? Are labels read at least three times – when picking the medication, preparing the dose, and prior to administration?	

ADDITIONAL QUESTIONS

What uncontrollable external factors influenced this outcome? (Identify any factors the organization cannot change that contributed to a breakdown in the internal process, for example natural disasters).

Were there any other factors that directly influenced this outcome? (List any other factors not yet discussed).

What are the other areas in the organization where this could happen? (Ensure planned actions include addition areas as needed).

What barriers were in place but failed to stop the undesirable outcome? What barriers SHOULD have been place but were not to prevent the undesirable outcome?

What uncontrollable, outside factors directly affected the result?

What human factors were relevant to the outcome? (examples: fatigues, personal problems, in-attentional blindness/ confirmation bias, substance abuse)

Summary	YES	NO
1. Was the event caused by an inappropriate action?		
2. Do policies/procedures exist for the activities/tasks involved?		
3. Do the policies/procedures related to the tasks have sufficient detail?		
4. Do the policies/procedures have sufficient fail-safe mechanisms?		
5. Do the policies/procedures cover tasks in proper sequence?		
6. Did the time of day have an effect on the event?		
7. Did the event occur at shift change?		

What other pertinent issues were identified not already addressed in the minimum scope of investigation as listed above?

CONCLUSIONS

Pertinent Conclusions	
Proximal Cause (s)	
Systemic Deficiencies	

Improvement Opportunities identified: (add rows as needed)

# 1.	
# 2.	
# 3.	
# 4.	
# 5.	

ACTION PLAN

*Method Key: (A) Policy (B) Education (C) Audit (D) Observation (add rows as needed)

#	Action Plan/Risk Reduction Strategies— Prevent Reoccurrence	*Method				Responsible Party	Target Date
		(A)	(B)	(C)	(D)		
1							
2							
3							
4							

Bibliography: Cite all books and journal articles that were considered in developing this root cause analysis and action plan.

DO NOT WRITE BELOW THIS POINT – RISK MANAGEMENT USE ONLY

Was the analysis completed within forty-five (45) days after determining that the occurrence is a sentinel event?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	If NO, Explain:	
------------------------------	-----------------------------	-----------------	--

Should this analysis be voluntarily reported to DNV?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain:	
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Action	Date

Date discussed in Performance Improvement / Quality Council:

Performance Improvement Review:

Medical Staff Review:

Legal Services Review:

Final Disposition: _____ Date: _____

ATTACHMENT II

Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

ANALYSIS AREAS	EVENT TYPE									
	Suicide (24 hr care)	Med. Error	Proced. Complic.	Wrong site surg.	Treatmt Delay	Restraint Death	Elopement Death	Assault/Rape/hom.	Transfusn Death	Infant abduction
Behavioral assessment process*	X					X	X	X		
Physical assessment process	X		X	X	X	X	X			
Patient identification process		X		X					X	
Patient observation procedures	X					X	X	X	X	
Care planning procedures	X		X			X	X			
Continuum of care	X				X	X				
Staffing levels	X	X	X	X	X	X	X	X	X	X
Orientation and training of staff	X	X	X	X	X	X	X	X	X	X
Competency assessment/credentialing	X	X	X		X	X	X	X	X	X
Supervision of staff		X	X		X	X			X	
Communication with patient/family	X			X	X	X	X			X
Communication among staff members	X	X	X	X	X	X			X	X
Availability of information	X	X	X	X	X	X			X	
Adequacy of technological support		X	X							
Equipment maintenance/management		X	X			X				
Physical environment	X	X	X				X	X	X	X
Security systems and processes	X						X	X		X
Control of medications: storage/access		X							X	
Labeling of medications		X							X	

MONTEVISTA

Title: SAFETY PLAN	Policy Number: 800.102
Function: EOC	Approved: 10/17 Revised: 01/18, 01/19
Manual: ENVIRONMENT OF CARE	Page(s): 13
Developed By: SAFETY COMMITTEE	Attachment(s): N/A

I. Objective and Scope

It will be the policy of Montevista Hospital (MH) to provide a work environment safe for the guest and employees and make every effort to prevent accidents.

II. Risk Assessment

It will be the practice of MH to perform safety risk assessments per policy 800.114.

III. Staff Development

MH will train staff to recognize and keep a safe environment. This will be accomplished through initial orientation safety topics, rounding that identifies safety issues, meetings, and policy familiarization.

IV. Emergency Response and Procedures

MH will have standards that guide safe action during related events such as the emergency preparedness manual.

V. Inspection, Testing, and Maintenance

Proper care of the MH facilities will occur on an ongoing basis through TELS PM and work order systems.

VI. Information Collection and Evaluation

MH records about safety practices and events will be used to improve safety.

VII. Performance Monitoring

MH tracks compliance with safety practices and policies.

VIII. Annual Evaluation

MH reviews its safety plan, policies and procedures.

POLICY:

Montevista Hospital will have an active safety plan to outline operation processes designed to manage staff activities which will reduce health care errors, the risk of human injury, and provide a safe physical environment for patients, personnel and visitors.

DEFINITIONS:

1. Error - an unintentional act either of omission or commission, or an act which does not achieve its intended outcome.

2. Sentinel Event - The sentinel event applies to events which meet the following criteria:
 - The event has resulted in an unanticipated death or major permanent loss of function¹, not related to the natural course of the patient's illness or underlying condition, (note: a distinction is made between an adverse outcome related to the natural course of the patient's illness or underlying condition [not a sentinel event] and a death or major permanent loss of function associated with the treatment, or lack of treatment, of that condition), or,
 - The event is one of the following (even if the outcome was not death or permanent loss of function):
 - Suicide of a patient in a setting where the patient receives around-the-clock care (e.g., hospital, residential treatment center, crisis stabilization center), or
 - Infant abduction or discharge to the wrong family, or
 - Rape, the determination of which is to be based on the hospital's definition consistent with applicable law and regulation. An allegation of rape shall be investigated and the root cause analysis initiated when the determination is made a rape has occurred, or
 - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities, or

¹ A major permanent loss of function means sensory, motor, physiological, or intellectual impairment not present or admission requiring continued treatment or life-style change. When major permanent loss of function cannot be immediately determined, root cause analysis may not be initiated until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

Root Cause Analysis (RCA): An evaluation process structured to attempt to determine underlying causes of the sentinel event and whether there is a reasonable potential for process improvement to reduce the likelihood of such events in the future. The following are characteristics of a root cause analysis:

- Focus primarily on systems and processes, not individual performance;
- Progression from special causes in clinical processes to common causes in organizational processes;
- The use of "Why?" repeatedly as each reason is determined; and

- Identification of changes, if any, should be made in systems and processes, either through redesign or development of new systems or processes, which would reduce the risk of recurrence of that sentinel event.
3. Critical Event - Critical event applies to events which meet the following criteria: The event results in or has the potential to cause serious harm or death (even if the outcome was not serious harm or death):
- Suicide of any patient other than an inpatient or who has been discharged from the facility's inpatient, partial hospitalization, outpatient or other service program within 30 days prior to the suicide, or
 - Attempted suicide of any patient (does not result in a major loss of permanent function), or
 - Any actual or alleged inappropriate sexual contact between staff and current patients or individuals who are patients within two years from discharge, (to include inappropriate verbal or written communication and/or inappropriate physical contact), or
 - Sexual contact between patients involving any touching of genitalia, or
 - Patient elopement, or
 - Staff/patient or patient/patient aggression resulting in injury to the patient, or
 - Medication error resulting in injury to the patient, or
 - Significant adverse drug reaction, including incidents where the correct drug and dosage were administered, yet the patient suffered a major reaction which may have precipitated a medical emergency, or
 - Falls with significant injury, or
 - Any other Class I Incident.

Critical Event Analysis: An evaluative process structure to attempt to determine underlying causes of the critical event and whether there is a reasonable potential for process improvement to reduce the likelihood of such events in the future. The following are characteristics of a critical event analysis:

- Focus primarily on systems and processes, not individual performance;
 - Progression from special causes in clinical processes to common causes in organizational processes;
 - The use of "Why?" repeatedly as each reason is determined; and identification of changes, if any, should be made in systems and processes, either through redesign or development of new systems or processes, would reduce the risk of recurrence of that critical event.
4. Near Miss - use to describe any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of a sentinel event but outside the scope of those sentinel events which are subject to review by the Joint Commission on Accreditation of Healthcare Organizations under its Sentinel Event Policy.
5. Hazardous Condition - any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of serious adverse outcome.

6. Medication Variance – any preventable event may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, or patient. Such events may be related to professional practice, pharmaceutical products, procedures, & systems, including prescribing; order communication; product labeling; packaging and nomenclature; dispensing; distribution; administration; education; monitoring; and use.
7. Adverse Drug Reactions (ADR): any undesired, unintended, excessive or exaggerated effect of a drug administered to a patient within the facility due to either the drug itself or patient idiosyncrasy (excluding gross overdose and therapeutic failure). These reactions may be expected or unexpected.

SAFETY PLAN PHILOSOPHY:

The focus of this plan is to identify and reduce risks to patient safety and employee safety. The hospital environment is one, which values the highest standards of quality and ethics integrity. Open communication and safety reporting is encouraged and a nonpunitive philosophy presides, focusing on systems and processes rather than individual blame. Individuals involved in a risk event (staff, visitor, patient, family) will be offered an opportunity to process/express feelings in a safe and therapeutic environment.

All departments/personnel are responsible to contribute to data collection, resolution of problems and continued monitoring using the PDCA PI model of safety issues. An interdisciplinary process (formal and informal) is encouraged to enhance positive outcomes. A competent work force is paramount in maintaining a safe practice; therefore every department will develop an employee competency program which is reviewed by Human Resources.

SCOPE:

The Safety Plan includes all buildings and facilities operated by Montevista Hospital and apply to all employees, physicians, and other independent practitioners, patients and visitors. It also applies to all activities conducted by staff members off site while conducting activities required by their position at the Hospital.

The scope of the Plan entails the following operational components: safety policies and procedures, safety education and training, hazard surveillance (including product recall), employee incident reports, security program, hazardous materials and waste Plan, emergency preparedness program, quality improvement program, risk Plan, life safety Plan, medical equipment Plan, utilities Plan and medical/health care errors/factors which contribute to unanticipated patient outcomes.

GOALS:

The Safety Plan functions to create a culture of safety by maintaining a safe environment for patients, personnel, and visitors through compliance with regulations, procedures, and standards set forth by OSHA, The Joint Commission, CMS, HIPAA, National Fire Code, the City of Las Vegas Fire Marshall's office and Standard Building Codes, Clark County, as well any Professional Discipline Regulatory Agencies.

Short-term objectives of the Safety Plan will be identified annually by the Safety Committee. These will be based on annual evaluation results of the Safety Plan and unresolved safety issues.

OBJECTIVES:

The objectives of the Plan are to:

- Establish and implement operational processes which guide, monitor and/or evaluate safety management practices.
- Identify the organizational components responsible for safety management functions at Montevista Hospital and delineate the relationship among these components including lines of authority, responsibility and accountability.
- Identify and resolve safety management issues which result in environmental hazards and unsafe practices with special attention to hazards related to the ages of the patients served.
- Evaluate results of actions taken by individual departments to meet safety recommendations.
- Provide at least monthly reports of safety management activities to Quality Council, Administration, and department heads, including the CEO.
- Provide effective process for supervising all grounds and equipment.
- Provide processes for conducting risk assessments that evaluate the buildings, grounds, equipment, occupants, and other physical systems on patient and public safety.
- Provide processes for reporting and investigating all incidents or abnormal occurrences which involve the building, patients, staff, and visitors.

RESPONSIBILITY AND AUTHORITY:

Chief Executive Officer: The Chief Executive Officer (CEO) has the responsibility, authority, and accountability for requiring, supporting the establishment and maintenance of an effective hospital-wide Safety Plan. The CEO has the responsibility to provide necessary staffing and equipment for the Safety Plan; and require hospital staff participation by all departments. The CEO has authorized the Safety Officer the responsibility for development, implementation, and monitoring of the Safety Plan. The CEO and Medical Director through the Medical Executive Committee authorize the Safety Officer to intervene whenever conditions exist that pose a threat of damage to equipment or building.

Quality Council: The Quality Council monitors the effectiveness of the Safety Plan and is authorized to designate resources and priority levels to the Safety Committee's recommendations. The Quality Council approves the annual Safety Plan.

Safety Committee: The Safety Committee is a standing committee designed to analyze identified safety management issues and to develop recommendations for resolving them. The Safety Committee is responsible for:

- The Safety Committee will meet every month with an agenda and minutes completed for each meeting.
- The Chairman of the Safety Committee will be appointed by the Chief Executive Officer.
- Review and revision of the Safety Plan policies and procedures for accuracy, completeness, and proper implementation.
- Monitoring system user training programs and directing changes as appropriate.
- Monitoring safety systems and processes as it relates to the overall quality of the patient care environment.
- Developing and monitoring Performance Standards for the Safety Plan.
- The Committee will receive on a regular basis summary reports from the following areas:
 - 1) Patient and visitor variances
 - 2) Personnel injuries and occupational illness incidents
 - 3) Personnel and visitor security incidents and property damage
 - 4) Medical equipment and utility management disruptions
 - 5) Hazard surveillance, product recall, fire safety, and all safety and security investigations
 - 6) Fire drill and emergency preparedness evaluation data
 - 7) Life Safety (to include all aspects of fire devices, i.e., sprinkling system, fire Extinguishing systems, etc.)
 - 8) Performance Improvement results of monitoring and evaluation activities related to Hazards and safety practices
 - 9) Risk Management issues related to hazards and safety practices
 - 10) Infection Control activities related to hazards and safety practices

The SAFETY Committee will make recommendations to analyze identified safety management issues and to develop and approve recommendation for solving them and to monitor the effectiveness of the changes to see if correction/improvement occurs.

The SAFETY Committee will receive results of the annual evaluation of the Safety Plan and revise as necessary and forward the plan to Quality Council.

Safety Officer: The Safety Officer has the responsibility to manage an ongoing hospital-wide process to collect and evaluate information about hazards and safety practices used to identify safety management issues to be addressed by the SAFETY Committee. The Safety Officer will:

- Report monthly to the SAFETY Committee on findings, recommendations, actions and monitoring conducted by the Safety Department. This includes but is not limited to hazard surveillance, product recall, fire safety, incident investigation.

- Participate in hazard surveillance, product recall and incident reporting on a regular basis.
- Participate in the development of departmental and organization-wide safety policies and procedures.
- Participate in Safety education orientation program for new employees and in continuing education for all employees.
- Be a member of the SAFETY Committee and Quality Council.
- Work with appropriate staff to implement SAFETY Committee recommendations and to monitor effectiveness of the changes.
- Prepare monthly reports of safety management issues and summaries of SAFETY Committee activities for communication and distribution to Quality Council and designated hospital personnel.
- The Safety Officer will work with the SAFETY Committee and Quality Council to develop and monitor Performance Standards for the Safety Plan.

Compliance Director: The Performance Improvement (PI) Director is responsible for the planning, implementation, monitoring and evaluation of Performance Improvement clinical activities including safety and risk events as well as proactive safety improvements and risk reduction strategies. The PI Director serves as a resource for regulatory compliance and risk management consultation. The PI Director works collaboratively with the Safety Officer to establish a Safety Plan and monitor the effectiveness of the plan. (Refer to PI and Risk Management sections)

Department Heads: Department Heads are responsible for establishing departmental safety programs. Safety precautions applicable to the department will be written form either collectively or inclusive in the various job functions. Each department head is responsible for employee safety awareness/education; monitoring or compliance to safety related policies and procedures; corrections of safety deficiencies and proper reporting of safety incidents/hazardous.

Employees: Hospital employees are responsible for adhering to safety policies and procedures, reporting environmental hazards and safety incidents/variances, and making recommendations for the improvement of the Safety Plan and the overall Environment of Care.

SAFETY RISK/ERROR REDUCTION:

1. Montevista Hospital recognizes a patient has the right to a safe environment therefore the organization is committed to undertaking a proactive program to identify processes which may adversely affect patient safety or be associated with medical errors.
2. Effective reduction of errors and other factors which contribute to unintended adverse patient outcomes in our organization requires an environment in which patients, their families, and organizational staff and leaders can identify and manage actual and potential risks to patient safety. Our environment must encourage:

- a. Recognition and acknowledgement of risks to patient safety.
 - b. Organizational focus on process and systems assessment and improvement related to patient risk and safety.
 - c. Initiation of actions to reduce these risks.
 - d. Internal reporting of what has been found and the actions taken.
 - e. Minimization of individual blame or retribution for involvement in a medical error.
3. Montevista Hospital has delegated oversight of our patient safety and error reduction program to Quality Council.
 4. Quality Council shall report to the Medical Executive Committee. Quality Council will on a regular basis aggregate and assess all organizational data related to adverse events; incident reports; risk management; environmental safety clinical outcome measurements; risk concerns and provide a report to the Medical Executive Committee.
 5. At least annually, Quality Council will select at least two (2) high-risk processes for proactive risk assessment and risk reduction. High-risk process selection shall be based on information published periodically by the Joint Commission or other nationally recognized sources of information on patient safety and medical errors. The processes selected for proactive risk assessment and risk reduction should include those processes known to be associated with sentinel events, significant patient risk or medical errors in other organizations.
 6. Quality Council shall oversee the development of a program to reduce medication related errors. The medication error reduction program shall incorporate the principles of medication error reduction which have been identified by the Joint Commission and by other nationally recognized sources of patient safety and error reduction strategies. Montevista Health recognizes medication errors as medication variances.
 7. Montevista Hospital understands inconsistency in the performance of existing organizational processes frequently leads to unanticipated and/or undesirable results. In order to minimize risk to patient safety due to undesirable process variations, Quality Council will require ongoing monitoring to ensure processes identified as variance prone or high risk regarding patient safety are being performed. Each year the performance of critical steps in at least two (2) processes shall be subject to ongoing measurement and analysis to determine the degree of variation from intended performance. If undesirable process variation is identified Quality Council shall refer their assessment findings to the appropriate committee or team for prioritization of a performance improvement project.
 8. Specific processes which should be considered for performance improvement prioritization. Identification of risk can occur through:
 - Self report
 - Performance Improvement reporting and trending
 - Proactive measurement of high risk, problem prone processes
 - Failure Mode Evaluation (including near misses)
 9. Safety risks will be categorized as Class I, II, III, IV
 - Class I Incidents: Patient event requires forwarding to Corporate Risk Management.

- Class II Incidents: Patient event requires internal tracking and trending.
 - Class III Incidents: Visitor general liability.
 - Class IV Incidents: Worker's Compensation, employee injury or concern.
10. Quality Council will assure knowledge-based information, including journal literature, clinical practice standards or guidelines, reference information and research data, is utilized in process design and process redesign. Quality Council shall assure knowledge based information is used and the development of at least one (1) clinical practice guideline (Best Practice) on an annual basis.

FUNCTIONS TO BE INCLUDED IN PATIENT SAFETY AND ERROR REDUCTION COMMITTEE DUTIES

Performance Improvement

1. Establish measurable objectives for improving patient safety and reducing medical errors. Measurable objectives shall be based on the elements of patient safety and error reduction which are described in this Plan.
2. Review of all sentinel/critical events including the development of a thorough and credible root cause analysis or critical event analysis, appropriate plan of correction, and follow up plan. See Sentinel Event and Critical Event Policies and Procedures #200.12 and #200.121.
3. Review and disseminate available information about sentinel events known to occur in other health care organizations which provide services similar to Montevista Hospital. This includes review of all The Joint Commission sentinel event alerts through Quality Council.
4. Assuring prioritization is given to those events and processes most closely associated with patient safety when developing the organizational measurement program and in selecting specific improvement activities.
5. Assuring the data which the organization considers for collection to monitor performance shall include the following:
 - a. Patient, family and staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety.
 - b. Staff willingness to report medical/health care errors/variances.
 - c. Data about the needs, expectations, and satisfaction of individuals and organizations served. Montevista Hospital will ask these groups specifically how the organization can improve patient safety.
6. Aggregating organizational information related to patient safety and medical errors to identify trends or patterns in process or outcome, which may lead toward patient events.
7. Assuring when organizational process is designed or redesigned, information from other organizations related to potential risks to patient safety, including occurrence of sentinel/critical events, is reviewed and risk reduction strategies are implemented in the designed or redesigned process.

Information Management

1. Quality Council shall work with appropriate organizational staff in developing the hospital information management needs assessment. The needs assessment shall include information regarding barriers to effective communication among caregivers. Specific attention will be directed to the processes for assuring accessibility of accurate, timely and complete verbal and written communication among caregivers and all others involved in the utilization of data (including external sources).
2. Working collaboratively with staff to assure the medical record is audited on a regular basis to verify all information necessary to assure patient safety and reduce medical errors is contained in the medical record in a timely manner.
3. Development of program to assure knowledge-based information is available to clinicians to support clinical management and decision making in a timely manner, including internet access, journal subscriptions, corporate and community networking and collaborative efforts.

Environment of Care (EOC)

1. Aggregate and assess organizational data related to environmental issues associated with patient safety and risk. Each of the seven (7) EOC elements have an individual management plan. These plans are reviewed annually by the Safety Committee, Quality Council and Medical Executive Committee. Additionally, departments develop specific safety policies to promote safety practices and reduction of risk opportunities. Refer to the EOC Safety Manual.

Risk Management

1. Provide oversight of all organizational risk management activities.
2. Develop an organizational-wide approach to the reporting and evaluation of potential medical errors.
3. Develop procedures for immediate response to medical errors including care of the affected patient, containment of risk to others and preservation of information for subsequent analysis. Refer to Addendum B.
4. Develop systems for internal and external reporting of information relating to medical errors.
5. Aggregation and trending of all risk management information to identify those events or processes which are associated with patient safety and/or medical errors.
6. Develop procedures to be followed related to the notification of patients and when appropriate their families about unanticipated error outcomes or medical errors. Refer to Addendum A.

Human Resources

1. Ensure each staff member participates in ongoing in-service, education, and training to increase his or her knowledge of job-related aspects of patient safety.
2. Assure ongoing in-service and other education and training programs emphasize specific job-related aspects of patient safety. As appropriate, this training incorporates methods of team training to foster the interdisciplinary collaborative approach to the delivery of patient care and reinforces the need and ways to report medical care errors.
3. Define a mechanism for the support of staff who are involved in medical errors or sentinel/critical events.

Patient and Family Education

1. Work with staff in the development of programs to enhance involvement by the patient and patient's family as appropriate to his or her condition as a partner in the health care process.
2. Oversee the development of programs to educate the patient and families about their role in helping to facilitate the safe delivery of health care.
3. Oversee the development of programs to educate patients and families regarding their responsibility for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
4. Work with staff to assure patient education programs are implemented related to safe and effective use of medications.

Safety Risk Continuum of Care

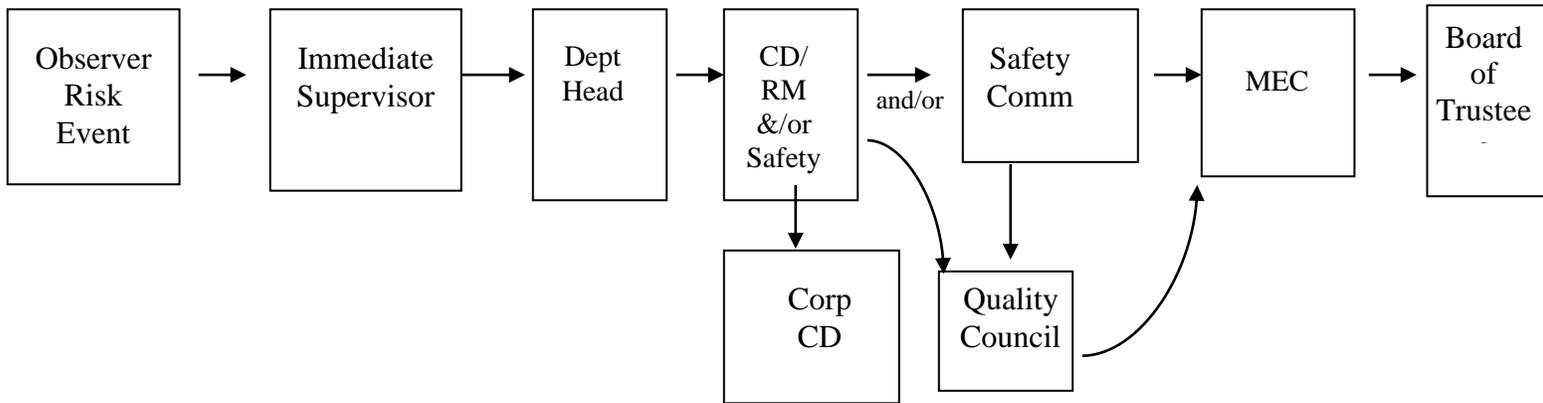
The patient and staff safety standards meet regulatory requirements throughout the continuum of care at Montevista Hospital. Department Heads review standards to ensure compliance for off-campus sites and when providing community services. Safety risk identification and follow through remains intact regardless of level of care or site location.

Safety Risk Event Documentation/Notification

It is the policy of Montevista Hospital that patients and, when appropriate, their families are informed about outcomes of care including unanticipated outcomes. It is the obligation of the responsible licensed independent practitioner or his or her designee to clearly explain the outcome of any treatment or procedure to the patient and, when appropriate, to the patient's family whenever those outcomes differ significantly from anticipated outcomes. Quality Council shall institute monitoring programs to assure information regarding unanticipated outcomes is shared with patients and, when appropriate, their families in a timely manner. Refer to Addendum A.

Risk events are to be accurately documented in the medical record. Patient and non-patient related events are to be documented using appropriate internal reporting tools. Routing of this documentation is diagramed below to ensure preservation of information to appropriate notification of key caregivers (i.e., attending physician, medical physician, therapist, etc.). To encourage accurate reporting the hospital supports the Supervisor's authority to impact changes to avoid similar risk events. This includes: time limited milieu modifications, import additional

staff or modify staffing pattern, notification of vendors or other department personnel to make necessary changes.



Performance Improvement Measurements Clinical Safety

1. Patient Satisfaction Survey: Created as a mechanism to review outcome study and recommend action to improve satisfaction scores.
2. Seclusion/Restraint Indicator: High volume of seclusion and restraints experienced. Corporate policy to reduce seclusion and restraints by 50%.
3. Staffing Effectiveness: Measurement of key indicators as they relate to patient and employee safety and staffing patterns.

Addendum A

The patients and family if applicable are to be informed of unanticipated outcomes by the attending physician/designee unless such information is deemed detrimental to the safety of the individual. Such a sanction requires a second opinion by a psychiatrist and administrative approval.

Patient/family notification is documented in the Progress Notes, signed by the attending physician and witness by an additional care giver attending the meeting. Should information be deemed detrimental, Risk Management is contacted and provides opportunity for the second opinion to be documented and reviewed by Administration. The approval or other direction is noted and followed accordingly.

Addendum B

Immediate response to medical errors:

- Follow communication algorithm for notification
- Provide care per policy and physician orders
- Supervisor to determine risk containment measure including
 - Staffing/personnel changes
 - Equipment replacement
 - Relocation of patients
 - Modification of processes/program
- Preservation of factual information
 - Event is to be documented immediately in Progress Notes and via Risk Management tools.
 - Equipment including videotapes, medical devices, instruments, photos are to be locked in Risk Management.
 - Event analysis is to occur within 24 hours of notification.
 - Events necessitating reporting to outside agencies (i.e., CPS, Adult Protective Services, Police, and insurance carriers) will be handled promptly and with full commitment to the governing regulations by the CEO or designee.

Policy:

It is the policy of MGGH to develop and implement, in consultation with the providers of health care, an internal Patient Safety Program to improve the health and safety of patients/residents who are treated at our facility.

Procedure:

1. The Patient Safety Plan at MGGH encompasses Acute care, Emergency room, surgical services, clinic and Home Maker Services and compliance with the Patient Safety Plan is mandatory.
2. Following approval of the safety plan by the Governing Body, the Medical Staff shall be notified as to the existence and requirements of the plan.
3. The Patient Safety Committee is comprised of a physician, a nurse from SNF, pharmacist, governing board member, risk manager, Infection Control Officer, Patient Safety Officer, and the Administrator

The Committee shall:

- Function under the authority of the Medical Staff
- Submit its patient safety plan to the Governing Board
- Meet monthly
- Investigate, report and formulate corrective actions related to alleged sentinel events
- Review Medical Equipment/devices safety and maintenance inspections
- Review and recommend actions related to medications events
- Review and investigate patient care related incident reports
- Additional tasks as assigned by the Medical Staff
- Annually review patient safety checklists and policies and consider any additional checklists and policies for appropriate adoption
- Revise check lists and policies to ensure they reflect the most current standards in patient safety protocols
- On or before July 1st of each year, submit a report to the Director of the Legislative Bureau for transmittal to the Legislative Committee on Health Care that includes information regarding the development, revision, and usage of the patient safety checklists and policies and a summary of the annual review conducted by the facility.

3. The Administrator shall appoint a Patient Safety Officer with the following responsibilities:

- Serve on the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred in the medical facility.
- Shall within 13 days of being notified of a Sentinel event or within 14 days of becoming aware without notification, report the date, time and brief description of the sentinel event to the health division, The Bureau of Licensure, Administrator and the Patient Safety Committee
- Take such actions as he/she determine necessary to ensure the safety of the patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility
- Report to the Patient Safety Committee regarding any actions taken
- The Patient Safety Officer may designate alternates to act in his/her absence. Kathy The Risk Manager will act as Patient Safety Officer in the absence of the Patient Safety Officer
- The Patient Safety Officer is responsible to review, investigate and act upon patient safety issues other than sentinel events at this facility, including medication errors, environmental issues and equipment and supply malfunction

4. Jan Kollodge RN DON has been appointed by the Administrator as Patient Safety Officer

POLICY: The Patient Safety Committee functions to enhance patient safety through data collection, reporting, investigation and evaluation of patient safety issues prior to an event and when an event occurs. All patient safety information will be confidential and reported through the Medical Staff Quality Assurance process.

PROCEDURE: The Patient Safety Committee shall:

- Receive reports from the Patient Safety Officer (PSO)
- Evaluate actions of the PSO in connection with all reports of sentinel events alleged to have occurred at MGGH
- Review and evaluate the quality of measures carried out to improve the safety of patients who receive treatment at MGGH
- Review and evaluate the quality of measures carried out by MGGH to prevent and control infections
- Make recommendations to the Governing Board of MGGH to reduce the number and severity of sentinel events and infections that occur at MGGH
- Monitor and document the effectiveness of the patient identification policy
- At least annually, review the patient safety checklists and patient safety policies appropriate for adoption for use by MGGH
- Revise a patient safety checklist and patient safety policy as necessary to ensure that the checklist or policy reflects the most current standards in patient safety protocols
- On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care with information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted in #3 above
- Forward Patient Safety Committee minutes/reports to the Medical Staff quarterly. Minutes will summarize MGGH patient safety activities.
- Report on a quarterly basis to the Governing Body of MGGH regarding:
 1. The number of sentinel events that occurred at MGGH during the preceding calendar quarter
 2. The number and severity of infections that occurred at MGGH during the preceding calendar quarter
 3. Any recommendations to reduce the number and severity of sentinel events and infections that occur at MGGH

PATIENT SAFETY DATA COLLECTION:

Patient safety data collection, review and reporting of the following patient safety events is a means of providing the safest patient care possible. Data collection will begin with the completion of a Quality Review Report.

- Sentinel events
- Adverse events
- Near Misses
- Medication errors and falls
- Equipment malfunctions
- Preventive corrective interventions

SUBJECT: MEETING AGENDA

DEPARTMENT: HOSPITAL WIDE

REFERENCE 4002

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 11/03 REVISED:

Patient Safety Committee Meeting Agenda

The Patient Safety Committee meets on the fourth Tuesday of each month.

Patient Safety officer: Jan Kollodge RN

Date:

Members Present:

Standard Agenda Items:

- 1. Sentinel Event**
- 2. Other Events**
- 3. Adverse Drug Events and medication errors**
- 4. Incident Reports**
- 5. Equipment/ Supply issues**
- 6. Root Cause Analyses Evaluation**

Old business:

New business:

Other:

SUBJECT: EMPLOYEE TRAINING/EDUCATION

REFERENCE 4003

DEPARTMENT: HOSPITAL WIDE

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 11/03 REVISED: 6/21/16

POLICY:

It is the policy of MGGH that all employees and individuals contracted for patient care receive Patient Safety Training and are familiar with the job related aspects of patient safety and staff specific roles and responsibilities to actively support patient safety

PROCEDURE:

All staff will receive patient safety education and training during their new employee orientation and on an annual and as needed basis. Contracted individuals will be monitored for compliance with patients safety policies by the supervisor of the department the contracted individual is assigned to.

SUBJECT: INTERNAL EVENT REPORTING

REFERENCE: 4004

DEPARTMENT: HOSPITAL WIDE

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 11/03 REVISED:

POLICY:

It is the policy of MGGH that prevention and reporting of harm to patients is the responsibility of all employees. Anyone with knowledge of an actual or patient safety event must report it.

PROCEDURE: Near Miss and Adverse Events

- Immediately notify your Department Director and complete a Quality Review Report.
- The supervisor will review and forward it to the Patient Safety Officer within 24 hours of receipt or the first work day following a week-end or holiday
- The Patient Safety Officer will review all reports and determine what specific actions are needed and forward them to Risk Management for review through the Quality Review Process
- All events will be reported to the Patient Safety Committee

SENTINEL EVENT REPORTING

Sentinel events signal the need for immediate investigation and response and any person employed by MGGH shall, within 24 hours after becoming aware that a sentinel event has occurred, notify the Patient Safety Officer of the sentinel event.

PROCEDURE:

- Immediately perform necessary health care interventions
- Notify the patient's Medical Provider and initiate all physician orders. If necessary contain the risk to others and preserve event related material that may require further investigation
- Document the facts in the medical record using concise, factual, objective and complete details
- Notify the appropriate department director and the Patient Safety Officer who will inform the Administrator and Risk Manager and in the case of an intentional unsafe act that results from gross negligence or possible criminal activity, report to the appropriate authorities.
- The Patient Safety Officer will notify the Bureau of Licensure and the Health Department on a form to be developed by them within the prescribed time restraints.
- All Sentinel events will be reported to and investigated by the Patient Safety Committee

POLICY:

It is the policy of MGGH to investigate all patient safety events that occur (actual event) or almost occurred (near miss) that caused or had the potential to cause harm to a patient.

PROCEDURE:

1. Upon notification of a patient safety event the Patient Safety Officer will review all pertinent data related to the event i.e. diagnostic testing, medication orders, medical records and interviews of the parties involved etc
2. Take any action deemed necessary at the time of the investigation
3. Form a plan to prevent recurrence of a similar event
4. In the event of a sentinel event, begin investigation immediately and take such actions necessary to ensure the safety of the patient.
5. Report the event and the results of the review, action taken, and the prevention plan to the Patient Safety Committee for their recommendations
6. The Patient Safety Officer will inform the appropriate supervisor of actions taken and the determinations of the Patient Safety Committee

DEFINITIONS:

Aggregate Review Analyses: The process of examining data elements for common trends or patterns.

Root Cause Analyses: The process for identifying the basic or contributing factors associated with patient safety events. It identifies changes that could be made to the system to improve performance and to reduce the risk of adverse events or the recurrence of near misses with the ultimate goal of reducing or eliminating patient harm.

POLICY:

It is the policy of MGGH to track and trend data to identify familiar trends or circumstances so that system issues can be identified and improved and to conduct a Root Cause Analyses and action plan to prevent the recurrence of similar events

PROCEDURE:

1. The Patient Safety Committee shall collect data from each patient safety event to perform an Aggregate Review Analyses.
2. The Patient Safety Committee will conduct a root cause analyses and complete an action plan for all sentinel events focusing on system and process changes to improve performance and to reduce the risk of adverse events.
3. The Root Cause Action Plan will enumerate the risk reduction strategies, implementation, and evaluation of the effectiveness of actions taken.
4. The Root Cause Action Plan will be submitted to the Medical Staff for approval

POLICY:

A patient safety event is defined as any incident that occurred (actual event) or almost occurred (near miss) that caused or had the potential to cause harm to a patient and shall be reported to Patient Safety Officer via the Quality Review Report.

- Near Miss: An event or situation that could have resulted in harm to a patient but did not, either by chance or through intervention.
- Adverse Event: An occurrence associated with health care or services that may or may not result in harm to a patient. These include incidents such as medication errors and patient falls even if there is no harm or permanent damage to the patient.
- Sentinel Event: An event included in Appendix A ‘Serious Reportable Events in Health Care__2001 Update: A Consensus Report. Sentinel events signal the need for immediate investigation and proactive response from MGGH.
- Facility –acquired infection: A localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility including: 1. surgical site infections 2. ventilator-associated pneumonia 3. Central line-related bloodstream infections 4. Urinary tract infections

SUBJECT: SAFE MEDICAL DEVICES REPORTING TO THE FDA

REFERENCE 4009

DEPARTMENT: HOSPITAL WIDE

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 11/03REVISED:

Safe Medical Devices Reporting to the FDA

POLICY:

It is the policy of MGGH to voluntarily report serious adverse events or product problems that are suspected to be associated with a drug or medical device to the FDA. All such events will be reported to the Patient Safety Officer and the Patient Safety Committee for review.

PROCEDURE:

The following reporting procedure will be followed

1. All adverse events or product problems will be reported to the Patient Safety Officer.
2. Department managers will be responsible for completion of the MED WATCH FDA reporting form (form 3500A)
3. The Patient Safety Officer will review and submit the completed form to
4. Forms are available in the Patient Safety Policy and Procedure manual

FDA
MedWatch HFD-410
5600 Fishers Lane
Rockville, MD 20857

POLICY:

Proper patient identification is required in order to prevent errors related to invasive procedures, medication administration, transfusion of blood products, and patient labeling of specimens. The use of patient identifiers improves the reliability of the patient identification process and decreases the chance of performing the wrong procedure on the wrong patient. It is the policy of MGGH to correctly identify patients prior to any procedures and before each interaction with a health care provider/

PROCEDURE:

The use of two patient identifiers is required to confirm a patient's identity.

1. Ask all patients for their NAME and DATE OF BIRTH prior to any treatments, procedures, or medication administration.
2. Label all specimen containers with the patient labels that are generated at admission.

MONITORING AND DOCUMENTATION:

1. Monitor medication errors related to wrong patient and report to Patient Safety Committee
2. Monitor incident reports related to wrong person procedures
3. Review the patient identification policies with the involved staff member
4. Perform a root cause analysis if indicated
5. Report as a sentinel event if indicated

POLICY:

Health Care Workers at MGGH are required to recognize and follow established nationally recognized standards of care.

PROCEDURE:

Nationally recognized standards of care are to be followed by all Health Care Workers relevant to their departments and to standards related to all departments involved in patient care. Established standards of care include, but are not limited to, the following:

1. Implementation of evidence based practice to prevent health care associated infections:
 - A. Hand hygiene based on CDC guidelines
 - B. CAUTI
 - C. Infections caused by multi-drug resistant organisms
 - D. Central line infections
 - E. Surgical site infections
 - F. Blood stream infections
2. Improve the accuracy of patient identification prior to any treatment, care, or services, using 2 patient identifiers
3. Report critical results of tests and diagnostics on a timely basis
4. Prevent pressure ulcers
5. Identify safety risks and prevent falls
6. Prevent wrong site, wrong patient, and wrong surgery
 - A. Mark the site
 - B. Time out before procedures
 - C. Surgical checklists
7. Improve the safety of medications
 - A. Label all IV medications accurately and completely
 - B. Use approved protocols for the initiation and maintenance of anticoagulation therapy
 - C. Maintain and communicate accurate patient medication records
 - E. 2 nurses to verify certain high risk medications before administration i.e. insulin, cardiac drips, heparin, etc.

SUBJECT: INFECTION CONTROL OFFICER

REFERENCE # 4013

DEPARTMENT: HOSPITAL WIDE

PAGE: 1 of 1

APPROVED BY: _____ EFFECTIVE: 10/1/11

REVISED:

POLICY:

MGGH has designated the DON as the Infections Control Officer for the facility which includes ER, OR, acute care, SNF, and the medical clinic. The Infection Control Officer also serves as the Patient Safety Officer at MGGH

RESPONSIBILITIES:

- Serves on the Patient Safety Committee
- Monitors the occurrences of infections to determine the number and severity of infections at the facility
- Reports to the patient safety committee concerning the number and severity of infections at the facility
- Shall take such action as he or she determines is necessary to prevent and control infections alleged to have occurred at MGGH
- Shall carry out the provisions of the infection control program adopted by NRS 439.865 and ensure compliance with the program
- Shall consult with the Health Division for education and technical assistance relating to infection control in medical facilities when indicated
- The Risk Manager will service as the Infection Control Officer in the absence of the Infection Control Officer. If neither one is available, the charge nurse is responsible.

POSITION REQUIREMENTS:

- Must be a Registered Nurse
- Must successfully complete a nationally recognized basic training program in infection control
- Must complete at least 4 hours of continuing education each year on topics relating to current practices in infection control and prevention
- MGGH shall maintain records concerning the required training

POLICY:

It is the policy of MGGH that when a patient at our facility has an infection, the provider of health care or the designee of the provider of health care shall, as soon as practicable, but not later than 5 days after the diagnosis is confirmed, inform the patient or legal guardian or other person authorized by the patient to receive such information that the patient has an infection. Notification of the patient may be delayed only if the patient does not have a legal guardian, has not authorized any other person to receive such information and:

1. Is not capable of understanding the information
2. Is not conscious or
3. In the judgment of the provider of health care, is likely to harm himself or herself if informed about the infection

If the provider of health care or the designee of the provider of health care delays providing information about an infection, such information must be provided as soon as practicable after:

1. The patient is capable of understanding the information
2. The patient regains consciousness
3. In the judgment of the provider of health care the patient is not likely to harm himself or herself if informed about the infection or
4. A legal guardian or other person authorized to receive such information is available

PROCEDURE:

1. At admission, all patients or their legal guardian sign a Release of Protected Health Information that lists who may be given information about their health condition
2. The provider of health care will consult this list when someone other than the patient must be given information about an infection
3. The provider of health care may authorize the Infection Control Officer, Risk Manager or other RN to inform the patient, legal guardian, or another person authorized by the patient of an infection
4. Notification will be verbal and will be documented in the medical record
5. If an infection is known or determined while the patient remains at MGGH, the patient or person authorized by the patient or the legal guardian will be notified whether the infection was acquired at the facility and of the apparent source of the infection

PATIENT LABEL

FOLEY CATHETER INSERTION AND MAINTENANCE CHECK LIST

	Patient identified using 2 identifiers?
	Is it necessary for patient care?
	Is there a doctor's order?
	Hand hygiene performed prior to procedure?
	Sterility of catheter kit verified?
	Sterile gloves applied?
	Area cleansed per protocol?
	Sterile drapes applied?
	Asceptic technique insured? May need assistance for some patients
	Foley bag hung on bed frame below patient's bladder?
	Leg strap on to prevent movement and urethral traction?
	UA obtained?
	Hand hygiene performed after procedure?
	Care Plan on chart?
	Daily catheter care performed?
	Foley to be removed as soon as possible? Assess for need every 24 HOURS
	Closed system maintained and additional UAs taken from sampling port

NURSE SIGNATURE _____ **DATE** _____

PATIENT LABEL

LIVER BIOPSY CHECKLIST

	Patient identified by name and date of birth
	Procedure verified with patient
	Anticoagulants held by patient as ordered by doctor
	Consent signed
	All equipment available
	Hand hygiene prior to procedure
	Sterile technique throughout procedure
	Specimens labeled correctly and delivered to the lab
	Post liver biopsy orders on chart and followed
	Patient given discharge instructions

NURSE SIGNATURE _____ **DATE** _____

APPROVED BY: _____ EFFECTIVE: 07/12/10 REVISED:

POLICY:

Patient Safety policies and check lists have been developed by MGGH to ensure the safety of our patients. Staff compliance with these safety components will be ensured by monitoring, peer-to- peer communication, sanitation audits, education, and when possible video monitoring.

PROCEDURE:

Compliance will be measured using the following methods and reported at the monthly Patient Safety Committee Meeting. Violations will be reported to the appropriate supervisor.

1. Chart audits
2. Staff monitoring by Department Supervisors
3. Staff monitoring by the Patient Safety and Infection Control Officer
4. Environmental sanitation audits
5. Department specific education
6. Video monitoring when possible

PATIENT LABEL

ISOLATION PRECAUTIONS CHECKLIST

	Appropriate isolation precautions selected?
	Isolation bag stocked and hanging outside of patient room
	Linen and red trash bags set up in room?
	Blood pressure cuff, stethoscope, and thermometer in patient room?
	Precaution signs, visitor and patient instructions posted outside of room?
	Visitor and patient instructions posted inside the room?
	Hand hygiene performed before going into room and before leaving?
	Isolation rules enforced with staff and visitors?
	Ancillary departments following isolation rules?
	Appropriate isolation precautions Care Plan in chart?

NURSE SIGNATURE _____ **DATE** _____

PATIENT LABEL

**PATIENT SAFETY
DISCHARGE CHECK LIST**

	Discharge Instructions Form Given?
	After care instructions included?
	Has patient designated a lay caregiver?
	Discharge plan provided to lay caregiver prior to discharge day?
	Is caregiver available at discharge?
	Written training and education given to caregiver at discharge if present?
	Follow up instructions?
	Activity instructions?
	Diet instructions?
	New medications explained and RX given or called to pharmacy
	Medication reconciliation form
	CHF instructions (the carbon copy instructions and diet instructions etc.)
	Teaching materials
	Name and relationship of person discharged to on DC instruction form?
	Telemetry removed?
	Medications from home given to patient at discharge?
	PNEUMONIA SHOT GIVEN (check for criteria being met and consent signed?)
	FLU SHOT GIVEN (during flu season)?
	PORTAL ACCESS COMPLETED WITH PORTAL ACCESS DOCUMENT PRINTED AND GIVEN TO PATIENT- MUST BE COMPLETED ON 100% OF ALL IN-PATIENTS

NURSE SIGNATURE _____ **DATE** _____

This check list to be filed with the Discharge Instruction form in the chart and completed at the time of discharge along with the standard discharge instructions and the CHF instructions

PATIENT LABEL

**PATIENT SAFETY
OBSERVATION DISCHARGE CHECK LIST**

	Discharge Instructions Form Given
	After care instructions included
	Follow up instructions
	Activity instructions
	Diet instructions
	New medications explained and RX given or called to pharmacy
	Medication reconciliation form
	CHF instructions (the carbon copy instructions and diet instructions etc.)
	Teaching materials
	Name and relationship of person discharged to on DC instruction form
	Telemetry removed
	Medications from home given to patient at discharge
	FLU SHOT GIVEN (during flu season)
	Health Information Exchange "Summary of Care" completed

NURSE SIGNATURE _____ **DATE** _____

This check list to be filed with the Discharge Instruction form in the chart and _____ completed at the time of discharge along with the standard discharge instructions and the CHF instructions

DINI-TOWNSEND HOSPITAL

PROTOCOL

SUBJECT: PATIENT SAFETY PROGRAM

NUMBER: DT-PI-02

Page 1 of 7

ORIGINAL DATE: 2/18/10

REVIEW/REVISE DATE: 7/18/13, 11/22/16, 10/23/18

APPROVAL: _____ Agency Manager

APPROVAL: _____ Local Governing Body

I. PURPOSE

To enhance patient care delivery and prevent adverse outcomes of care by employing a systematic, coordinated, and continuous approach to the improvement of patient safety.

II. PROTOCOL

The Patient Safety Program is supported by leadership's promotion of a blame-free culture of safety that:

1. Facilitates reporting and follow-up on errors, adverse events, risks, and safety concerns.
2. Initiates, monitors, and takes action to reduce errors and risks of errors.
3. Reports findings and actions taken.
4. Educates employees to ensure their knowledge of and participation in the program.

III. DEFINITIONS

1. Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.
2. Near Miss: Any process variation which did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome.
3. Health Care-Associated Infection (HAI): A localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility.
4. Incident: An event that is not consistent with routine patient care or hospital procedure which either did or could have resulted in injury, loss to a patient, employee, or visitor; or which may give rise to a claim against the hospital, an employee, or a member of the medical staff.
5. Error: An unintended act, either omission or commission, or an act that does not achieve its outcome such as medication errors and adverse drug events or reactions.
6. Just Culture: Recognizes that individual practitioners are not held accountable for system failings, competent professionals make mistakes, but has zero tolerance for reckless behavior.

IV. REFERENCES

1. Nevada Revised Statutes (NRS) 439.865 to 439.890 Patient safety plan; patient safety committee; patient safety officer; patient safety checklists and policies.
2. NRS 439.802 Facility-acquired infections defined.

3. The Joint Commission Comprehensive Accreditation Manual for Hospitals, National Patient Safety Goals and Patient Safety Systems Chapters.
4. Dini-Townsend Hospital Protocol DT-EC-08 Environmental Safety and Security Management.
5. Dini-Townsend Hospital Protocol DT-IC-06 Hand Hygiene.
6. Dini-Townsend Hospital Protocol DT-IC-07 Standard Precautions.
7. Dini-Townsend Hospital Protocol DT-PI-03 Sentinel Events.
8. Division of Public and Behavioral Health (DPBH) electronic Discharge Interdisciplinary Continuity of Care Form (ICOC).

V. OBJECTIVES

1. To collect and analyze data to evaluate processes for opportunities to proactively reduce risk and correct potential system failures.
2. To respond appropriately to any error, adverse event, or sentinel event.
3. To incorporate recognition of patient safety as an integral job responsibility.
4. To encourage organizational learning about adverse or potential adverse events.
5. To improved hospital safety culture by encouraging reporting, measuring safety culture on a regular basis, and involving employees in addressing needed change.

VI. SCOPE

- A. Areas of focus include sentinel events, near misses, errors, and other incidents related to:
 1. Health care-associated infections.
 2. Medication errors.

3. Adverse drug events.
 4. Drug recalls.
 5. Other product recalls.
 6. Patient falls.
 7. Other patient incidents.
 8. Blood and body fluid exposures.
 9. Communicable disease exposures.
 10. Influenza vaccination program.
- B. Data from external sources, including but not limited to:
1. The Joint Commission.
 2. Centers for Medicare and Medicaid Services.
 3. Centers for Disease Control and Prevention.
 4. Institute for Safe Medication Practices.
 5. National Quality Forum.

VII. PATIENT SAFETY COMMITTEE

- A. The Patient Safety Committee provides a multidisciplinary forum for the analysis of risk to patient safety and for the dissemination of information on identified risk for the purpose of improving patient care.
- B. Membership includes:
1. The Patient Safety Officer – Accreditation and QAPI Manager.
 2. The Agency Manager.
 3. The Director of Nursing.
 4. The Director of Pharmacy Services.
 5. The Infection Control Officer.
 6. The Environmental Safety Officer - Facilities Supervisor.
 7. The Medical Director or other member of the medical staff.

- C. The Patient Safety Committee has adopted patient safety checklists and policies, including, but not limited to:
1. Checklists related to treatment or specific types of treatment.
 2. Checklists ensuring that the patient's environment is sanitary.
 3. An electronic discharge form which includes instructions concerning aftercare and medications (ICOC).
 4. Other checklists that may ensure patient safety.
 5. A procedure for appropriately identifying a patient with two personal identifiers.
 6. A hand hygiene protocol regarding standard precautions.
- D. The Patient Safety Committee meets monthly and will:
1. Review reports and evaluate the actions of the Patient Safety Officer on sentinel events and other incidents.
 2. Review, discuss, and evaluate Root Cause Analyses (RCAs) and corrective actions associated with serious incidents.
 3. Review emerging research and best practice standards related to patient safety.
 4. Promote a hospital-wide coordinated effort to comply with The Joint Commission's National Patient Safety Goals and Patient Safety Systems chapters.
 5. Review and disseminate information it receives to the appropriate committees or individuals, including, learned lessons from incident reports, to increase awareness and promote continuous improvement and a just culture.
 6. Make recommendations concerning identified risks and evaluate the implementation of corrective action plans.
 7. Review the patient safety checklists and policies at least annually and revise as necessary.

8. Ensure compliance with the patient safety checklists and policies, which may include:
 - a. Hand hygiene monitoring.
 - b. Audits of sanitation logs.
 - c. Review of health records.
 - d. Performance improvement indicator reports.
 - e. Communication to employees.

E. The Patient Safety Officer will:

1. Serve on the Patient Safety Committee.
2. Manage the agency incident reporting system.
3. Report all sentinel events to the Nevada Sentinel Event Registry, and to The Joint Commission where applicable.
4. Conduct investigations, RCAs, and monitor corrective action plans for completion and effectiveness.
5. Take action in collaboration with the Patient Safety Committee and leadership to ensure the safety of patients.
6. Report quarterly, to the Local Governing Body, the number and severity of sentinel events, and any recommendations to reduce the number and severity of sentinel events.
7. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report will include a summary of any new checklist development, or, revision and use of the checklists and policies.
8. On or before March 1st of each year, submit a report to the Nevada Sentinel Event Registry, summarizing the previous calendar year's sentinel events and Patient Safety Committee activities.

VII. SAFETY IMPROVEMENT ACTIVITIES

- A. Incident reporting trending and analysis.
- B. Medication error reporting and trending.
- C. Other potential errors/prescription interventions tracked by pharmacy.
- D. Infection surveillance and prevention.
- E. Monitoring hand hygiene.
- F. Tracking assault, seclusion and restraint data.
- G. Appropriate implementation of input from patients, families, and employees.
- H. Environmental safety rounds.
- I. Environmental safety monitoring by Environment of Care Committee.
- J. Reactive analysis (RCA) of incidents.
- K. Proactive risk assessment (failure mode effect analysis).
- L. Antibiotic Stewardship Program.
- M. Culture of Safety Employee Survey.

VIII. EMPLOYEE EDUCATION AND TRAINING

- A. Employees are educated on safety issues, policies, protocols, and procedures during new employee orientation, including department specific orientation.
- B. Annual employee education includes safety education.
- C. Employees are updated on all new agency protocols or protocol revisions.
- D. Employees participate on teams for proactive or reactive analysis and are, thus encouraged to participate in the improvement of safety.
- E. Employees are provided feedback on the results of the Culture of Safety Survey.
- F. Employees participate with leaders in addressing Culture of Safety Survey data.



**Risk Management/
Patient Safety Plan
Nevada Acute Care Division**

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 1 of 20

I. Overview

Northern Nevada Medical Center endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. Northern Nevada Medical Center operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that Northern Nevada Medical Center remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by Northern Nevada Medical Center to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at Northern Nevada Medical Center. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with Northern Nevada Medical Center policies. Northern Nevada Medical Center employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
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- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.
- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

Northern Nevada Medical Center mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 3 of 20

- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

Northern Nevada Medical Center recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

Northern Nevada Medical Center has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 4 of 20

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

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

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

C. Patient Safety

Northern Nevada Medical Center has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. Northern Nevada Medical Center has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 5 of 20

electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Control Provider, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 6 of 20

Northern Nevada Medical Center PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility’s claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the “Best Practice.”
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 7 of 20

- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Northern Nevada Medical Center is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 8 of 20

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 9 of 20

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

Element IX. Measuring the Effectiveness of the Risk Management Program: In order to assure the effectiveness of the Risk Management Program, certain activities should be conducted to ensure that implementation of the TERM program has been successful. This includes, but is not limited to, data analysis and trending of events and potential claims, which are shared with the respective oversight committees.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. ClearSight (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 10 of 20

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

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

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 11 of 20

Utilization of the “5 Whys” technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking “why” no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs. of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 12 of 20

H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 13 of 20

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 14 of 20

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. Risk Management Goals and Objectives 2019

- Surgical and Procedural Safety.
 - Goal: Zero harm events- Prevent errors in surgeries and procedures
- Emergency Department Safety
 - Goal: Reduction/ Elimination of Workplace Violence
- Medication Safety
 - Goal: Continue to implement an effective Opioid – Pain Management strategy, as evidenced by compliance with Assembly Bill 474, NRS 233B.066, regarding prescribing of controlled substances and reporting of controlled substance overdoses; Increase medication event reporting.
- Gap Analysis/Risk Assessments
 - Goal: Identify, evaluate and minimize potential risks.
- Risk management education
 - Goal: provide education to staff on identified key risk areas and topics such as confidentiality, patient safety, medication administration, equipment, professional conduct, duty to warn, suicide risk assessments, restraints,

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 15 of 20

- seclusions, documentation, release of information, consents for treatments/procedures, chain of command, and universal protocol.
- Event analysis/RCA
 - Goal: to identify breakdowns in processes and systems that contributed to the event and to develop corrective actions on how to prevent future events.
- Escalation/Chain of Command policy re-enforcement
 - Goal: to resolve problems/concerns related to patient care and to support patient safety by maintaining standards of care
- Reduce falls by 10% and/or meet goal set forth on dashboard. Goal = <97 falls
- Reduce E-I risk incidents by 5%. Goal <9
- Increase overall incident reporting by 10%. Goal >1865

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council Coaching

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors,

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 16 of 20

decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

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

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

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and BH.

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 17 of 20

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.” http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 18 of 20

treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 19 of 20

Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 20 of 20

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				

Title: Patient Safety/Risk Management Plan		Policy No. PI-101
		Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14, 1/17, 02/18, 02/19	Page 21 of 20

Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013.

Encompass Health Rehabilitation Hospital of Las Vegas

Policy#:

180

Title:

Patient Safety Plan

Category:

Plans

Policy Status:

Published

Effective Date:

09/21/2017

Last Reviewed Date:

02/21/2019

PROCEDURE

PURPOSE:

The purpose of the Patient Safety Program is to improve patient safety and reduce risk to patients, staff and visitors. Recognizing the effective medical/health care error reduction requires an integrated and coordinated approach; HealthSouth Rehabilitation Hospital of Las Vegas has developed an organization-wide safety program. The program supports the creation of an environment in which patients, their families, and organization staff leaders can identify and manage actual and potential risks to patient safety.

OBJECTIVE:

It is the objective of HealthSouth Rehabilitation Hospital of Las Vegas to foster an environment to improve patient safety, establish mechanism to support effective responses to actual occurrences and to be proactive in the reduction of medical/health care errors. Patient safety will be a priority in new design and all relevant organization processes, functions and services.

SCOPE:

The scope of the patient safety program will include compliance with standards identified by external regulatory agencies and accrediting bodies. Program activities will address occurrences ranging from "near misses" to sentinel events with serious adverse outcomes.

DEFINITIONS:

Actual Event-an event occurred that reached the patient or individual (e.g., visitor fall, student injury, etc.).

Near Miss-an event occurred but it did not reach the patient because of chance alone or because of active recovery efforts by caregivers.

Unsafe Condition- circumstances that could cause adverse events (e.g., look-alike medications, confusing equipment, failure to use proper signage when floor is wet).

Sentinel Event- is defined as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Severe temporary harm which is defined as critical, potentially life-threatening harm lasting for a limited time with no permanent residual effect, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition. (Hip fractures are always included)
- Permanent harm
- Death

For additional events also considered "sentinel" reference the HealthSouth Sentinel Event policy

PROCEDURES:

A. The responsibility for management of the organization-wide patient safety program is assigned to the Director of Quality/Risk Management and Patient Safety Officer.

1. The Safety Committee and Quality Council will provide interdisciplinary input related to patient, visitor and staff safety.

2. Reports of safety related activities and issues would be presented to Department Managers, Senior Staff, Medical Staff via the Medical Executive Committee, and the Governing Board. This communication is confidential and for quality assurance purposes only.

B. Staff will report information relating the medical/health care events as outlined in Risk Management Electronic Event Reporting Policy.

1. Staff will be oriented to the Risk Management Policies on hire and through ongoing in-service and other education and training programs.

2. Staff will be oriented to their roles in preventing adverse occurrences as related to their specific job responsibilities and as a part of the organization-wide efforts to improve patient safety.

3. Staff will be oriented to the importance of reporting "near misses," as well as adverse occurrences.

4. Team training to foster an interdisciplinary, collaborative approach to patient care delivery and to reinforce the need and way(s) to report medical/health care errors will be provided as appropriate.

5. The Director of Quality/Risk Management, Department Managers, and Senior Staff are responsible for interacting with staff in a manner that ensures staff do not fear disclosure, embarrassment, blame or punishment for reporting potential or actual events related to patient safety.

6. The Director of Quality/Risk Management, Department Manager and/or Senior Staff member may request the assistance of external resources if a staff member(s) needs support in coping with a sentinel event.

C. Hospital leadership will identify barriers to effective communication among caregivers relative to patient care, redesign the process to eliminate barriers and monitor for effectiveness. Specific attention will be directed to:

1. Process for ensuring accurate, timely, and complete verbal and written communication among care givers and all others involved in utilization of data, and

2. Test results relative to the management of the patient's condition.

D. All patients are entitled to information about all aspects of their health care, including information about clinically relevant unanticipated outcomes of care.

Patients and, when appropriate, their families are informed about the outcomes of care including unanticipated outcomes (i.e. sentinel events, State reportable events). Responsibility for disclosing unanticipated outcomes typically rests with the physician or designee who has overall responsibility for the patient's care. However, in some situations, other healthcare professionals may be deemed more appropriate to be responsible for disclosing the outcome. A hospital representative, preferably the Quality/Risk Director, Chief Nursing Officer or the Chief Executive Officer should be present for the initial conversation and any follow-up discussions that may occur with the patient and/or patient's representative.

E. The Director of Quality/Risk Management or designee will respond immediately to notification of significant medical/health events to a patient/visitor or staff member.

1. The Nursing Supervisor or Department Manager will contact the Risk Manager and/or Administrator/Administrator-On-Call to report events.

2. Action(s) will be taken to protect the patient/visitor/staff members as indicated per hospital plans and policies.

3. Factual information will be obtained and preserved for subsequent analysis. Such information is confidential for quality assurance purposes.

F. The facility will review historical risk management, Environment of Care (EOC), Program Improvement (PI) and Human Resources (HR) data for high volume, high risk problem trends in medical and care processes, as well as unanticipated adverse occurrences affecting patients. These will be ranked as:

- A. Unsafe condition (Non-event)
- B1. Near Miss - No Harm/Didn't Reach Patient/Caught by Chance
- B2. Near Miss - No Harm/Didn't Reach Patient b/c of Active Recovery by Caregiver
- C. No Harm – Reached Patient No Monitoring Required
- D. No Harm – Reached Patient Monitoring Required
- E. Harm – Temporary, Intervention Needed
- F. Harm – Temporary, Hospitalization Needed
- G. Harm - Permanent
- H. Harm – Permanent, Intervention Required to Sustain Life
- I. Death

G. The facility will also perform intense analysis consistent with the Root Cause Analysis/Sentinel Event Policies, and reports as required by state, regulatory, and accreditation bodies. The Risk Management designee is responsible for ensuring compliance with reporting.

H. Emerging needs requiring reprioritizing performance improvement activities may be identified through data collection and assessment, unanticipated adverse occurrences affecting patients, changing regulatory requirements, significant patient and staff needs, changes in the environment of care, or changes in the community. Priority consideration in establishing performance improvement teams is given to:

1. Processes that affect a large percentage of patients.
2. Processes that place patients at risk, if not performed well, if performed when not indicated, or if not performed when indicated.

Processes that have been or are likely to be problem prone.

I. When designing/redesigning processes, Department Managers and staff will:

1. Incorporate information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesigned process, function or service.
2. Conduct literature searches to obtain evidence based medical and/or care practices to be included in process redesign.
3. Include analysis and or pilot testing to determine whether the proposed design/redesign is an improvement.

J. Hospital leadership will consider the importance of patient safety in:

1. Development of hospital-wide patient care programs, policies and procedures that describe how patients' care needs are assessed and met.
2. Development and implementation of the hospital's plan for the provision of patient care.
3. Decision-making structures and processes.
4. Implementation of an effective and continuous program to measure assesses and improves performance.
5. Development of an interdisciplinary culture that emphasizes cooperation and communication. The leadership role of coaching will be used to promote communication among services, individual staff members and less formal structures such as quality action teams, performance-improvement teams or members of standing committees.
6. Development of a process to involve the patient, as appropriate to his/her condition, as a partner in helping to facilitate the safe delivery of care.
 - a. Patients/family members are oriented on admission of the importance of reporting perceived risks and concerns about the patient's care per Patient and Customer Complaint and Grievance Policy.
 - b. Department Managers and Senior Staff will review Press Ganey Patient Satisfaction Survey questions related to patient safety and develop a corrective action plan to patient/family complaints or suggestions for improving safety as appropriate.
7. The Governing Board will appoint the Director of Quality and Risk Management (DQRM) as the Patient Safety Officer. The Patient Safety Officer/Director's role includes:
 - Participating in hazard surveillance, event reporting, reviewing, and the development of patient safety policies and procedures.

- Analyzing and seeking resolution of patient safety issues and works with the appropriate staff to implement recommendations and to monitor patient safety improvement activities.
- Report on findings, recommendations, actions taken, and results of measurements through the hospital quality structure.

K. At least one (1) high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance, a minimum of 1 proactive risk assessment every 18 months. The process selected will be based, in part, on the information identifying the most frequently occurring sentinel events and patient safety risk factors.

1. Assess the intended and actual implementation of this process to identify steps in the process where there is, or may be, undesirable variation (i.e. called potential "failure modes").

2. For each identified "failure mode, "identify the possible "effect(s)" and how serious the possible effect on the patient could be (i.e. "criticality "of the effect).

3. For the most critical effects, conduct a root cause analysis to determine the variation (failure mode) leading to that effect occur.

4. Redesign the process and/or underlying systems to minimize the risk of that failure mode to protect patients from the effect of that failure mode.

5. Test and implement the redesigned process.

6. Identify and implement measures of the effectiveness of the redesigned process.

7. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

L. Hospital leadership will measure and assess the effectiveness of their contributions to improving patient safety. To accomplish these goals, leaders will.

1. Set measurable objectives for improving patient safety.

2. Actively request staff to periodically discuss their opinions, needs, perceptions of risks to patients and suggestions for improving patient safety. The actions taken as a result of this staff input will be reported to the MEC/GB at bi-annually.

3. Review data on staff willingness to report medical/health events.

4. Review data from Press Ganey Patient Satisfaction Survey related to patient safety.

5. Use pre-established, objective process criteria to assess their effectiveness in improving patient safety.

6. Draw conclusions based on their findings and develop and implement improvement in their activities.

7. Evaluate their performance in supporting sustained improvement.

M. The DQRM will report at a minimum quarterly to the Governing Board occurrences of medical/health events and actions to improve patient safety.



Quality, Patient Safety Plan

2019

This plan was created and revised by the Renown Health's Quality and Patient Safety Committee (QPSC). Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes. In addition, the plan is intended to encourage recognition, reporting, and acknowledgment of risks to patients, visitors, and employees as well as reduce medical/healthcare errors and/or preventable events. In addition this plan serves to direct the assessment of those services furnished directly by the organization or through contracted service, to identify opportunities to improve quality of those services and to implement appropriate corrective or improvement activities following the Plan, Do, Study, Act or PDSA model.

Quality and Patient Safety Plan

Contents

Commitment to Quality and Patient Safety	3
Mission, Vision, and Values	3
Scope and Purpose.....	3
Roles and Responsibilities.....	4
Components and Methods	6
Patient Safety Checklists and Patient Safety Policies	7
Approval of Quality and Patient Safety Plan	7

Commitment to Quality and Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, Renown Health's Quality and Patient Safety program promotes:

- Collaboration of leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Honest, open communication to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and values for each patient, family member, employee, and other healthcare providers.
- Responsibility for safety related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible patient outcomes.
- Incorporation of evidence-based safety practice guidelines to deliver high quality healthcare.
- Education of staff, physicians, new learners, patients and their families to promote patient safety and continuous quality improvement.

Scope and Purpose

This Quality and Patient Safety Plan applies across the entire Renown Health Acute Care Division.

All staff and physicians in Renown Health Acute Care Division are required to fully support and participate in this plan, and devote their expertise to the quality, patient safety, service and healthcare performance improvement process.

The purpose of this plan is to address safety, quality and service related concerns, challenges and to proactively identify opportunities to better serve patients and their families.

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

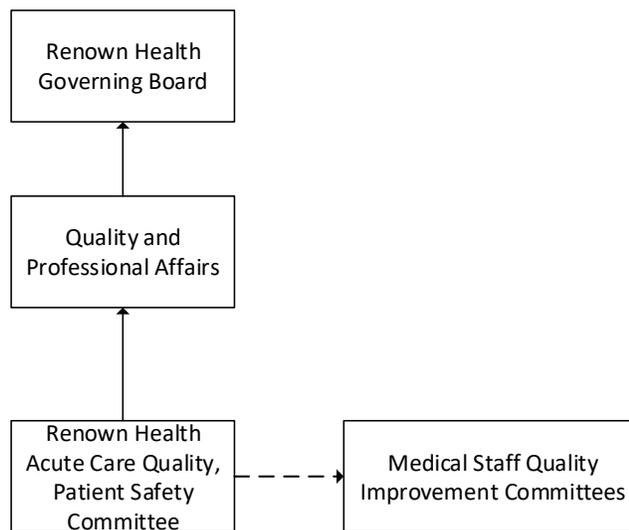
- Staff and physicians contributing their knowledge, vision, skill, and insight to improve the processes of quality, patient safety and service
- Promoting the concept that decisions are made based on data and facts
- A customer-focused approach including patients, families, and visitors

- System-based thinking
- Utilization of trained, expert staff and physicians.

Roles and Responsibilities

The Renown Health Acute Care Quality and Patient Safety Committee ensures that the Quality, Patient Safety Plan is promoted and executed successfully.

The Quality and Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), the Renown Health Acute Care Quality and Patient Safety Committee is comprised of:
 - The Renown Health Acute Care Infection Control Officer;
 - The Renown Health Acute Care Patient Safety Officer;
 - At least three providers of healthcare who treat patients, including at least one member of the medical, nursing and pharmaceutical staff;
 - One member of the executive or governing body;
 - A representative from Executive Leadership.

Quality and Patient Safety Committee Responsibilities (based in part on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy through event review and analysis when applicable.

- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
 - Number of sentinel events from previous calendar month
 - Number of hospital acquired infections that occurred in the organization
 - Corrective action plans for the sentinel events and infections.
- Review and evaluate the quality of measures carried out by the organization to improve the quality and safety of the care provided to patients.
- Review and evaluate the quality of measures carried out by the organization to prevent and control infections.
- Make recommendations to the executive or governing body of the organization to reduce the number and severity of sentinel events and infections.
- At least once each calendar quarter, report to the executive or governing body of the organization regarding:
 - (1) The number of sentinel events that occurred;
 - (2) The number and severity of infections that occurred; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
- A meeting agenda and minutes noting follow-up tasks will be kept.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the Renown Acute Care Quality and Patient Safety Committee.
- Supervise the reporting of all sentinel events alleged to have occurred, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred.
- Report to the QPSC directly or through his/her designee any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on in part on [NRS 439.873](#))

- Serve on the Renown Acute Care Quality and Patient Safety Committee.
- Monitor the occurrences of infections to determine the number and severity of infections.
- Report to the QPSC the number and severity of infections either directly or through his/her designee.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred.
- Carry out the provisions of the infection control program adopted pursuant in part to [NRS 439.865](#) and ensure compliance with the program.

Quality and Professional Affairs Committee of the Renown Health Board

- Provide vision and leadership that informs the safety processes, and develops and foster a safe learning and improving culture.
- Ensures the priorities of patient safety are aligned with the strategic priorities of the health system.

Components and Methods

The Renown Acute Care Quality and Patient Safety Committee uses data as a basis for recommendations for improvement.

Upon the identification of a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Root Cause Analysis

Renown Health Acute Care Division will use Root Cause Analysis (RCA) to determine the contributing factors and the underlying reasons for the deficiencies or failures involving sentinel events. Transformational Health Care principles and methods are incorporated into Renown’s RCA process.

An RCA is a process for identifying the root causes of process deviation or failure. It follows the principles of Just Culture by focusing on process reliability and failure rather than individual policy violation or failures.

Root Cause Analysis (RCA) Team Responsibilities

RCAs are conducted for all identified sentinel events and significant events/near misses involving complex process failure. Results of significant RCAs will be reported and monitored by the QPSC. RCA team responsibilities include:

- Conducting interviews in a fact-based, non-judgmental manner, analysis, investigation, and corrective action plan facilitation
- Coordination and participation in the RCA meetings and discussions
- Communicating in an honest and open manner regarding data and facts to with the team members and their supervisors/leaders
- Incorporating the principles of Just Culture in the RCA process.

Data Collection and Reporting

Data drives efforts to improve quality, safety and service. Renown Health uses Midas+ and other databases for tracking sentinel events, healthcare infections, patient grievances and other patient safety related data.

External data sources are also utilized for improvement efforts. These include but are not limited to:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention

- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Patient Safety Checklists and Patient Safety Policies

Another process used to improve quality, safety and service is the development of patient safety checklists and patient safety policies. Renown Acute Care anticipates that these checklists are utilized by:

- Providers of healthcare who provide treatment to patients at the organization;
- Other personnel who provide treatment or assistance to patients;
- Employees who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the organization; and
- Persons with whom the organization enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Renown Health Acute Care Quality and Patient Safety Committee reviews and approves annually patient safety checklists based on policy.

The Quality and Patient Safety Plan includes an infection control program that carries out the infection control policy. This program exists as individual and separate documents and consists of:

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

The Renown Health Infection Prevention Plan and Program is established and approved by the Renown Health Infection Control Committee. Regular reports and updates regarding the Infection Prevention Program are provided to the Patient Safety Committee.

Approval of the Quality and Patient Safety Plan

The Renown Health Quality and Patient Safety Plan is reviewed and updated annually and is approved by the Quality and Professional Affairs Committee of the Renown Health Board.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current Quality and Patient Safety plan must be submitted to the Division of Public and Behavioral Health.

Saint Mary's Regional Medical Center:

PATIENT SAFETY PLAN

DATE: 01/21/2019

VERSION: 01

NAME HERE

RN,MSN,CPHRM



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

All documents, materials and/or information prepared or created for the purpose of compliance with state law and/or peer review are confidential and deemed protected by the confidentiality provisions of any subsequent federal or state statute providing protection for related activities. Patient Safety files and their entire contents will be clearly marked —CONFIDENTIAL--and should not be copied or distributed without the advice of Legal Counsel.

Patient Safety Committee/Program

Saint Mary's Regional Medical Center:

235 West Sixth Street
Reno, NV 89503
(775)770-3000

Contents

Commitment to Patient Safety.....3
 Mission, Vision, and Values3
Scope and Purpose.....3
Roles and Responsibilities.....4
 Roles and Responsibilities5
Objectives and Goals of the Patient Safety Plan7
Components and Methods7
 Root Cause Analysis.....8
 Model for Improvement.....9
 Data Collection and Reporting.....10
Assessment of the Patient Safety Plan11
Patient Safety Checklists and Patient Safety Policies11
Approval of Patient Safety Plan.....14
Reference.....15
Appendix A: Terms and Definitions16
Appendix B: Patient Safety Goals18
Appendix C: RCA21
Appendix D-1: PDSA Worksheet.....25
Appendix D-2: PDSA Monthly / Quarterly Progress Report27
Appendix E: Checklist Example: Code Neuro.....28
Appendix F: Policy Example29

Commitment to Patient Safety

Saint Mary's Regional Medical Center is committed to providing quality healthcare to all patients. The Patient Safety Plan serves as a framework to establish and maintain a safe patient care environment. It expands the organization-wide support for risk management, performance improvement, information management, education, human resources and patient's rights by implementing patient safety standards, measuring and monitoring their effectiveness, and creating a "culture of safety" as part of the overall quality program.

Mission, Vision, and Values

In support of our mission, vision, and values, Saint Mary's Patient Safety program promotes:

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

Scope and Purpose

The scope of this Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
 - Visitor safety
 - Employee safety
- A. Saint Mary's recognizes that patients, staff and visitors have the right to a safe environment. Therefore, the organization commits to undertaking a proactive approach to the identification and mitigation of medical errors through the integration into and participation of all components of the hospital into the hospital wide program. This includes Performance Improvement, Risk, Infection Control and EOC programs.
 - B. The Patient Safety Plan promotes the use of internal and external knowledge and experience to identify, analyze, and prevent the occurrence of medical / healthcare errors and identify areas of opportunity to maintain and improve patient safety.
 - C. Patient safety information will be analyzed from aggregated data reports. All types of events can be addressed including "no harm", "near misses", and "sentinel events".

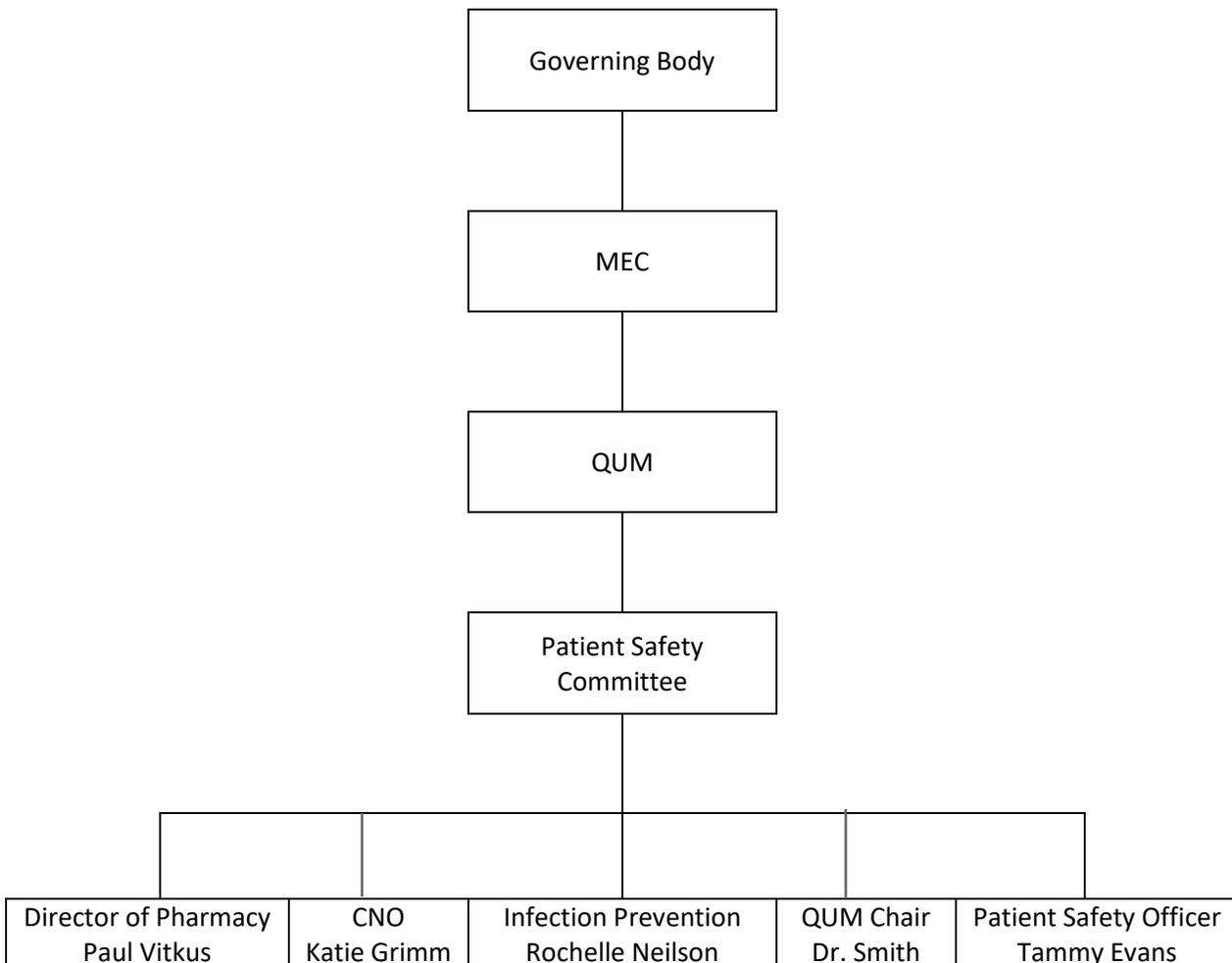
These reports will be reported to appropriate hospital and Medical Staff committees and to the Governing Board at regular intervals. The aggregate data will be used to prioritize organization-wide patient safety efforts.

- D. The organization also recognizes that despite our best efforts, errors can and will occur. Therefore, it is the intent of the organization to respond quickly, effectively, and appropriately when an error does occur.
- E. The organization also recognizes that the patient has the right to be informed of the results of treatment or procedures whenever those results differ significantly from anticipated results.

Roles and Responsibilities

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

The Patient Safety Committee Organization



Roles and Responsibilities

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

The roles and responsibilities are defined below

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

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

- Selects at least one high-risk patient safety process for proactive risk assessment (FMEA) at least every 12-18 months. Coordinates the process throughout this period.
- Presents Patient Safety reports to all departments.
- Develops, and recommends new policies and procedures for patient safety based on analysis of data from events, and other relevant information.
- Works in conjunction with the EOC Chair to prioritize risks, review and analyze data and performs risk analysis as needed to address the safety of the patient environment.
- Maintains the confidentiality and legal privilege, as appropriate, of all data and information.
- Facilitates patient safety orientation and in-service education programs.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

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

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.

The Patient Safety Committee will meet monthly to accomplish the following:

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

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Improve Hospital Handoffs & Transitions	Use TC tools to standardize handoffs within and across hospital departments. Goal: Improve Hospital Handoffs & Transitions by 10% or more by the next Safety Attitude Survey. Current AHRQ value 16%	Saint Mary's will implement a performance improvement team with a bottoms-up approach to problem solving led by bedside employees. We will collaborate with physicians, nurses, and non-clinical staff to address both clinical and non-clinical processes associated with handoff communication. We will have a bias toward action implementing small tests of change utilizing the PDSA model.	July 1, 2019	Alexandra Heidema
Reduce Mislabeled Specimens	Use standardized data collection and process review to determine causation links	Saint Mary's will implement a mislabeled specimens committee to review data and report progress towards zero events to QUM	July 1, 2018	Sarah Jensen
Improve response rate of AHRQ Safety Attitude Survey	Increase respondents by 30%	Focus on patient care areas by removing non-clinical departments from denominator	November 30, 2019	Tammy Evans

Components and Methods

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

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

changes.



Root Cause Analysis

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

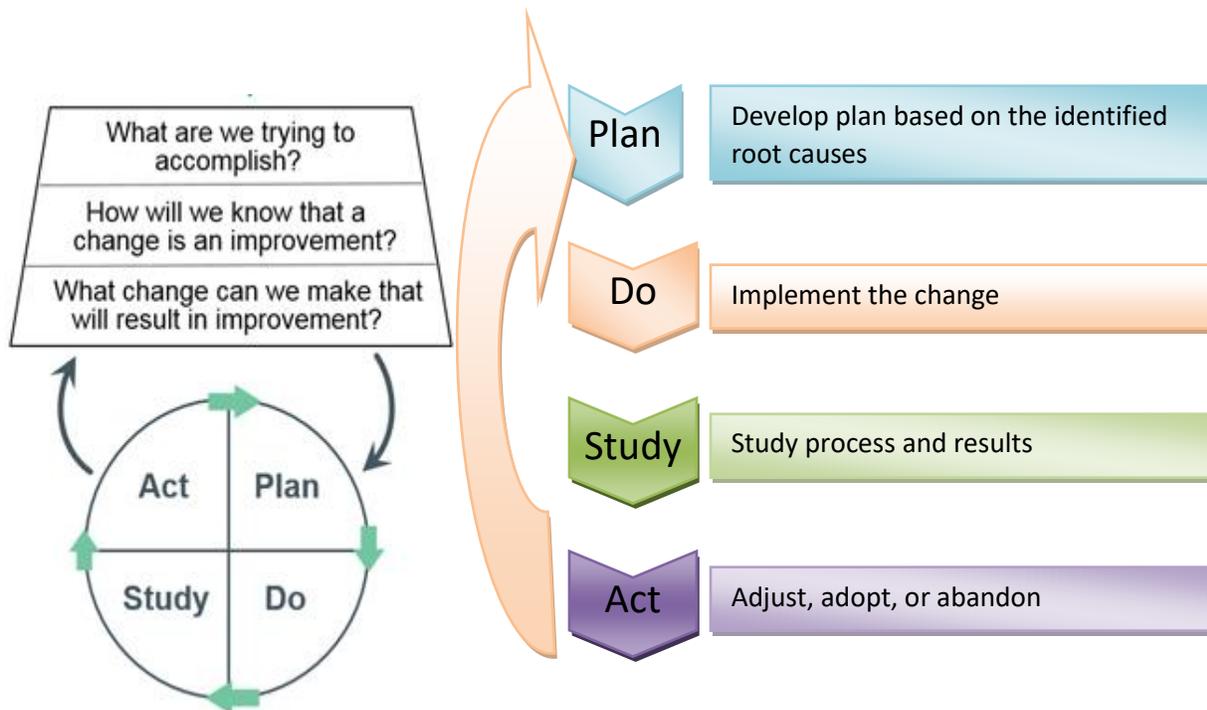
Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Saint Mary's to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times.

Model for Improvement

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



The cycle is defined as follows:

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

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

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

In order to reduce the likelihood of patient incidents and negative outcomes, Saint Mary's shall track the frequency and type of medical errors and compile them in order to learn from and prevent future negative occurrences.

1. External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:
 - a. AHRQ: Agency for Healthcare Research & Quality
 - b. CDC: Centers for Disease Control and Prevention
 - c. CMS: Centers for Medicare & Medicaid Services
 - d. NQF: National Quality Forum
 - e. NHSN: National Healthcare Safety Network
 - f. TJC: The Joint Commission
2. Internal data sources:
 - a. Risk incident reports with database compilation
 - b. Adverse Drug Events and Adverse Drug Reactions
 - c. Data from patient complaints
 - d. Risk Management and Safety findings
 - e. Compliance findings
 - f. PI and special study findings
 - g. Infectious Disease information
 - h. Employee surveys
3. Risk Assessment (Failure Mode and Effect Analysis)

An assessment that examines a process in detail including sequencing of events; accesses actual and potential risk, failure, points of vulnerability; and through a logical process, priorities areas for improvement based on the actual or potential patient care impact (criticality).

4. Data Analysis

Analysis of collected data will be undertaken to monitor and identify levels of performance, trends or patterns that vary significantly from expected outcomes and the need for possible change/improvement in systems or processes.

5. Process Improvement

When undesirable outcomes are identified, the hospital shall involve the personnel, resources, disciplines, and department/services most directly involved with the process to reduce future risk.

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;

- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

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

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. Saint Mary's has a separate Infection Prevention Plan developed by our certified Infection Preventionist. This document is available upon request.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Approvals

_____	_____
Director Risk Management	Date
_____	_____
Chief Nursing Officer / Administrator	Date
_____	_____
Chief Executive Officer	Date
_____	_____
Chairman, QUM Committee	Date
_____	_____
Chief of Staff	Date
_____	_____
Governing Board	Date

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);

- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

Goal 1 - Improve the accuracy of patient identification.

NPSG.01.01.01

Use at least two patient identifiers when providing care, treatment, and services.

NPSG.01.03.01

Eliminate transfusion errors related to patient misidentification.

Goal 2 - Improve the effectiveness of communication among caregivers.

NPSG.02.03.01

Report critical results of tests and diagnostic procedures on a timely basis.

Goal 3 - Improve the safety of using medications.

NPSG.03.04.01

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups, and basins.

NPSG.03.05.01

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.

NPSG.03.06.01

Maintain and communicate accurate patient medication information.

Goal 6 - Reduce the harm associated with clinical alarm systems.

NPSG.06.01.01

Improve the safety of clinical alarm systems.

Goal 7 - Reduce the risk of health care-associated infections.

NPSG.07.01.01

Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

NPSG.07.03.01

Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals.

Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.

NPSG.07.04.01

Implement evidence-based practices to prevent central line-associated bloodstream infections.

Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

NPSG.07.05.01

Implement evidence-based practices for preventing surgical site infections.

NPSG.07.06.01

Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

Note: This NPSG is not applicable to pediatric populations. Research resulting in evidence-based practices was conducted with adults, and there is no consensus that these practices apply to children.

Goal 15 -The hospital identifies safety risks inherent in its patient population.

NPSG.15.01.01

Identify patient at risk for suicide.

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
2. Address the patient's immediate safety needs and most appropriate setting for treatment.
3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

Universal Protocol

UP.01.01.01

Conduct a pre-procedure verification process.

UP.01.02.01

Mark the procedure site.

UP.01.03.01

A time-out is performed before the procedure.

Appendix C: RCA

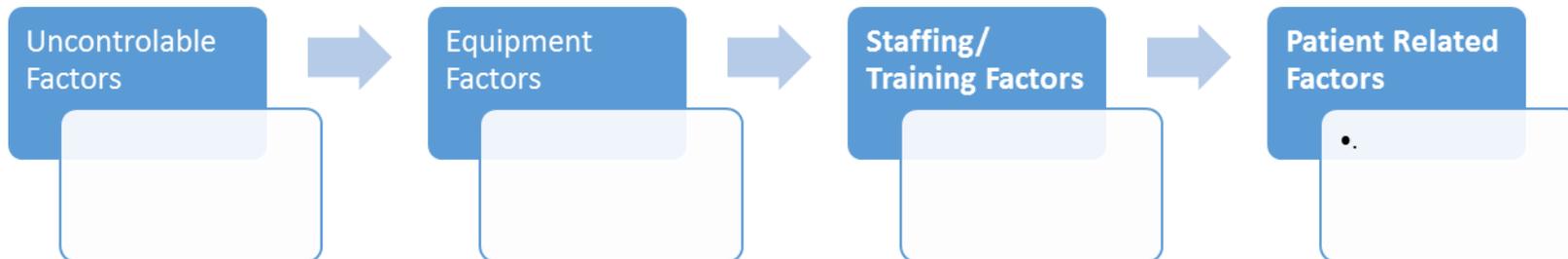
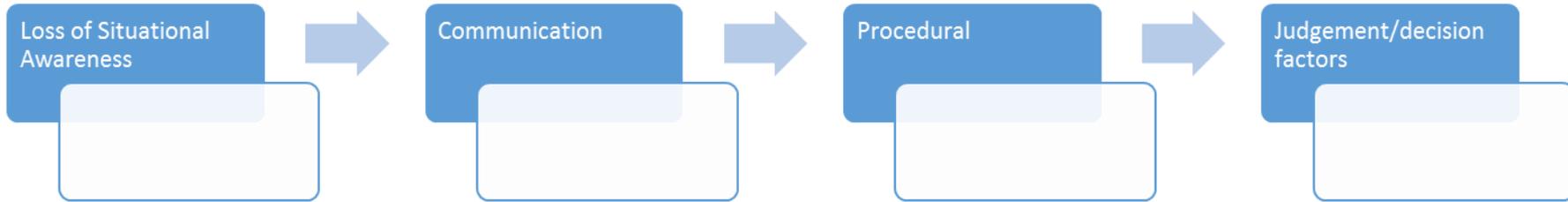
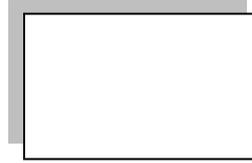
Narrative:

Key Factors:

Timeline:

Date / Time	Description of Event as relates to RCA	Concerns Noted	Employee(s) involved

Cause and Effect Diagram (or process flow chart):



Undesirable Outcome:						
Search for Causes:	Cause Identified	Description of Cause	Human Error	Described Human Error and/or Variance from P/P	Causal Link	Take Action?
Patient Related						
Situational Awareness						
Communication						
Proficiency						
Judgment						
Training						
Leadership						
Staffing						
Mechanical Failure						
Other						

Action Plan

Concerns	Action Plan	Responsible Party	Due Date	Status

Participants:

Literature Review:

Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CNO/COO			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	
<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Code Neuro

Code Neuro - New Item ✕

EDIT


Save
Commit


Cancel


Paste
Clipboard


Cut
Clipboard


Copy
Clipboard


Attach File
Actions


ABC
Spelling
Spelling

Last Known Well Time 12 AM 00

Events prior to Code Neuro Call

Total NIHSS Score

Was head CT done

Were Labs ordered

Was Primary MD called

Was Stroke Program Coordinator notified

Name of recorder

Name of primary MD

Name of Primary RN

Name of Code Neuro Team RN

Supervisor

Was Patient transferred

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

 <p>Saint Mary's Regional Medical Center</p>	<p>Policy and Procedure</p>	<p>Perioperative Services Labor & Delivery/OR Cath Lab Interventional Radiology</p>
<p>Universal Protocol</p>		

POLICY: Universal Protocol (Procedure Verification, Correct Site Management and Time Out For Invasive Procedures)

All patients undergoing a surgery or invasive procedure are to be considered at risk for the potential of a wrong patient, procedure or wrong site surgery/invasive procedure. The process to prevent wrong patient, wrong procedure and wrong site surgery or invasive procedure includes all required elements of the *Universal Protocol*. To assure that the correct procedure (operative or invasive) is performed on the correct patient and body part or site. Certain patients are considered at higher risk for error such as those undergoing multiple procedures with one or more physicians, those undergoing emergency procedures, or those patients that have unusual characteristics such as a physical deformity or massive obesity.

DEFINITIONS:

Procedure Verification: Includes verification of patient, procedure and site and as applicable, any implants, diagnostic/radiology results, blood, devices and special equipment (as appropriate to the type of surgery or procedure) AND is applicable to all departments performing surgical or invasive procedures, inclusive of bedside procedures.

Invasive Procedure: Any procedure performed which involves a puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including but not limited to percutaneous aspirations, biopsies, cardiac and vascular catheterization, central line placements, epidurals and endoscopies. This policy does not apply to certain routine minor procedures such as peripheral IV line placement, insertion of an NG tube or urinary catheter insertion.

Procedure Room: Any room where a surgical or invasive procedure may occur to include the patient's bedside.

Procedure Personnel: The RN or credentialed personnel who are participating in the invasive procedure

PROCEDURE:**A. General Information**

- Procedures NOT within the Scope of the Universal Protocol and this policy:
 - Venipuncture
 - Peripheral intravenous line placement
 - Insertion of nasogastric tube
 - Urinary catheter placement
 - ECT (electroconvulsive therapy)
 - Closed reduction
 - Radiation oncology
 - Lithotripsy (this does have laterality, but the stone is visualized during the procedure)
 - Dialysis (except insertion of the dialysis catheter)

- All other invasive procedures are within the scope of the Universal Protocol and this policy.

- Department staff and physicians participating in a surgical or invasive procedure will actively participate in the Procedure Verification process (to include pre-procedure verification, site marking, and time out) as described in this policy, to assure the correct patient, procedure and site (as applicable) is assessed prior to any surgical or invasive procedure. Staff will document the verification steps in the medical record.

- Anytime there is a discrepancy in the Procedure Verification process, the person discovering the discrepancy will re-verify all the previously completed steps against the surgery schedule, the history and physical, the permit, the patient and notify the physician and department manager. The procedure will not begin until clear verification of the patient, procedure and/or site is completed.

- All actual and "near miss" wrong patient, wrong procedure or wrong site procedures will be reported promptly to the Department Manager or designee and Risk Manager.

B. Pre-Procedure Verification

- Verification of the correct person using two identifiers (patient's name & date of birth), correct site, and correct procedure will occur with the patient/family/legal representative involved, awake and aware, if possible and documented.

- Additionally, persons responsible for scheduling the procedure, completing preadmission testing/assessment and admitting the patient will verify the procedure and site with the physician, physician's office or physician order.

- Pre-procedure verification will occur at the following times:
 - At the time the procedure is scheduled (to include implant information if applicable).
 - At the time of preadmission testing & assessment
 - At the time of admission or entry into the facility for a procedure, whether elective or emergent
 - Before the patient leaves the pre-procedure area (i.e. Same Day Unit or Pre-op Holding) or enters the procedure room

- Anytime the responsibility for care of the patient is transferred to another member of the procedural care team, (including the anesthesia providers), the above information will be communicated during the hand-off
- Additionally, in the pre-procedure area, procedure verification will include the following for patients undergoing a surgical or invasive procedure and be documented. All applicable items will be available in the procedure room/area and matched to the patient:
 - Identification of the procedure scheduled and identified in physician documentation
 - Presence of current, updated and complete History and Physical
 - Consent accurate, complete and signed by patient/representative
 - Provider assessment (MD, Nursing, PA, APN) and pre-anesthesia /procedural sedation assessment completed and documented
 - Marking of the procedure site by the physician prior to the procedure (if applicable)
 - Verification of the correct patient position
 - Availability and documentation of correct and labeled implants, diagnostic/radiology results, blood, devices and special equipment, or special requirements
- Scheduled procedures that involve anatomical sites that have laterality, surface (flexor, extensor), levels or specific digits or lesions, the word(s) left or right or bilateral will be written out fully on the procedure/operating room schedule and on all relevant documentation including the procedural consent or permit.

C. Site Marking

- Site marking is conducted for all procedures involving incision or percutaneous puncture or insertion.
- The marking takes in to consideration anatomical laterality, the surface (flexor, extensor), the level (spine) or specific digit or lesion to be treated.
- In cases where bilateral structures are removed (such as tonsils or ovaries) the site does not need to be marked.
- If one side is definite and the other is possible, only mark the definite site (example: right ovary, possible left ovary, only mark the right side).
- The only exceptions to site marking are:
 - Midline, single organ procedures
 - When both bilateral structures are to be removed.
 - Endoscopies without laterality
 - Procedures when there is no pre-determined site of insertion, such as cardiac catheterization, interventional radiology and amniocentesis.
 - When the use of direct imaging (fluoro x-ray, ultrasound imaging, CT fluoro or MRI imaging) is utilized by a physician present from the time the site is selected through the completion of the procedure. This applies to all cases where the performing physician uses imaging to select and/or navigate and/or complete the procedure.
- The site marking is completed for all procedures involving incision or percutaneous puncture or insertion by the physician or proceduralist performing the procedure prior to the time the patient is moved in to the procedure room/location. The patient/family/legal representative should be involved in the site marking process.

- The physician or proceduralist will identify the patient (using the two patient identifiers) and verify the procedure and site with the patient/family/legal representative.
- In collaboration with the patient or patient's family member, the site will be marked with the initials of the physician performing the procedure using an indelible marker prior to the patient being transferred to the procedure/operating room unless the anatomical site is exempted per policy.
- The site initialed will be made at or adjacent to the incision site, and must be visible after the patient is prepped and draped and positioned in the final position.
- If the procedure involves multiple sides/sites during the same operation, each side and site must be initialed.
- Do not mark any non-operative site(s).
- In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure, is familiar with the patient, will be present when the procedure is performed, and is either qualified through a medical residency program or is a licensed individual who performs duties requiring collaboration or supervisory agreements with the licensed independent practitioner (i.e., PA, APN).
- For spinal surgery, a two-stage marking process will occur as follows:
 - The general level of the procedure (cervical, thoracic, lumbar, or sacral) will be initialed pre-procedure, along with an indication of the right vs. left if applicable.
 - Intra-operatively, the exact interspace will be precisely marked using the standard intraoperative x-ray.
- The site will not be marked with the letter "X" or the word "No."
- A new marking pen will be used for each patient
- If the patient refuses to be marked, procedural personnel will re-educate the patient regarding the importance of site marking and document. If the patient still declines to be marked, the procedural personnel will notify the physician, document what alternative means was utilized for marking. The patient's refusal to be marked must be resolved between the procedural physician and the patient prior to the invasive procedure.
- If the consent was signed and the patient was marked accordingly, and then it was discovered that the site was incorrect before the incision was made, the procedure can proceed at the discretion of the procedural physician. The procedural personnel as per hospital policy will document an occurrence report.

D. Difficult to Mark Site:

- Sites which are technically difficult or anatomically impossible to mark or minimal access procedures treating a lateralized internal organ, will apply the alternative process below:
- Examples: Arm in cast, ureters through a cystoscope, teeth, or premature infants.

- After verifying with the patient/family/legal representative that the patient identification and procedural information is correct, the procedural personnel will place a patient sticker and the procedural information on an orange band, indicating the 'side' with 'Left' or 'Right'.
- The orange band information will be verified and initialed by the physician, then placed on the patient's ankle. If the patient's anatomy or procedural draping prevents visualization of the band during the time out process then the band will be placed on the patient's wrist.
- The orange band will be removed in the PACU or post-procedure recovery location.
- Teeth. The physician will initial on the dental radiographs or dental diagram each tooth involved in the surgery/procedure. The dental radiograph or diagram will be used during the time-out before the procedure to identify the site during the "time-out".
- Premature Infants: The orange band will be applied as in no. 1 above.

E. Time Out

- The time out is the suspension of all other activities to permit all members of the surgical/ procedural team to focus on active confirmation of the required time out elements. The circulating nurse or technologist will initiate the time out, although any member of the team may do this. These elements include:
 - Correct Patient: Patient identification using the two patient identifiers (patient name & date of birth).
 - Correct Site: Verification/confirmation of procedure site and side as specified on the consent and visualization of site marking that it is correct and agrees with consent
 - Correct Procedure: Accurate procedure and consent form per physician's order.
 - Confirmation of antibiotic administration
 - Consensus with all team members that above information is correct
 - Documentation of the "time out/procedure verification" process
- The procedure will not be initiated until all members agree with all elements included in the time out.
- The time out will be initiated by the procedural personnel after the patient has been prepped and draped and immediately prior to the initiation of the procedure with all team members present in the room or at the bedside.
- Whenever there is more than one procedure performed by separate procedure teams, there will be a time-out completed and documented by the separate procedure teams. The time out will precede each individual procedure.
- If there is any discrepancy among the team members during the time-out, re-verification will occur with a review of the surgical/department procedure schedule, history and physical, procedure consent, radiology films, consultations and any other information available to validate the correct patient, procedure and site.

F. Management Following Discovery of Wrong Patient/ Wrong Site/ Wrong Procedure

- If, after induction of anesthesia, during the course of a surgical/invasive procedure, or after a surgical/ invasive procedure has been completed, it is determined that the procedure being performed or completed is the wrong patient, wrong procedure or at the wrong site, the surgeon/physician and anesthesiologist will:
 - Act in accord with the patient's best interests and to promote the patient's well-being.
 - Record the event accurately in the medical record.

- Procedural personnel will immediately inform the department manager who will immediately notify the Risk Manager per hospital policy.

G. Fire Risk Assessment

- A fire risk assessment shall be done prior to the start of all surgical procedures (Perioperative Areas)
 - Performed before start of procedure
 - All members of the team participating
 - Communicated during the "Time Out"
 - Documented in patient record
 - Fire Risk Assessment Tool:
 - A. Is an alcohol-based prep agent or other flammable solution being used preoperatively?
 - B. Is the surgical procedure being performed above the xiphoid process or in the oropharynx?
 - C. Is open oxygen or nitrous oxide being administered?
 - D. Is an electro-surgical unit, laser, or fiber-optic light being used?
 - E. Are there other possible contributors (i.e. defibrillators, drills, saws, or burrs)?

H. Quality Improvement:

Compliance with the Universal Protocol Policy will be monitored by conducting documentation/observation audits on a monthly basis.

DOCUMENTATION:

Surgical/Procedural Consent

Procedural/Surgical Nursing Record

Preprocedure Safety Checklist

REFERENCE/EVIDENCE BASED PRACTICE:

Prime HealthCare Policy: Universal Protocol: PeriOperative

AORN Position Statement: Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events; August 2015

AORN's Fire Safety Tool Kit

The Joint Commission, 2016 National Patient Safety Goals.

The Joint Commission FAQ's 2009 Universal Protocol; November, 2008 Sentinel Event Alert-Wrong Site Surgery

Physician Insurer's Association of America (PIAA). Claims Data
 American Academy of Orthopedic Surgeons: Report on Wrong-Site Surgery Feb 1998

Bulletin of the American College of Surgeons, Vol. 87, No. 12, December 2002.

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APPROVAL:

Committee Approvals	Date
Surgical Services Executive Committee	12/13
Procedural Safety Team	12/13
Committee Approvals	Date
Policy Committee	6/16
QUM	6/16
MEC	8/16
BOARD	

Origination date: 09/01

Reviewed/Revised: 10/02, 12/02, 02/03, 06/03, 08/03, 10/03, 05/04, 04/05, 11/05, 08/06, 07/07, 05/08, 12/08, 02/09, 04/09, 04/10, 10/12, 12/13, 6/16

**Dignity Health – St. Rose Dominican
Rose de Lima Campus
PATIENT SAFETY/RISK MANAGEMENT PLAN**

DATE: 01/2019



This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
St. Rose Dominican – Rose de Lima Campus
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Henderson, NV 89052
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Contents

Commitment to Patient Safety.....	3
Mission, Vision, and Values	3
Scope and Purpose.....	3
Roles and Responsibilities	4
Roles and Responsibilities	4
Objectives and Goals of the Patient Safety/Risk Management Plan	10
Components and Methods	11
Root Cause Analysis	14
Model for Improvement	15
Data Collection and Reporting.....	15
Ongoing Reporting and Review.....	15
Assessment of the Quality and Patient Safety Plan	16
Patient Safety Checklists and Patient Safety Policies	16
Approval of Patient Safety Plan.....	17
References	18

Commitment to Patient Safety

Dignity Health St. Rose Dominican Hospital – Rose de Lima Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Dignity Health – St. Rose Dominican, Rose de Lima Campus' Patient Safety/Risk Management program promotes:

- Honest, open collaboration and partnership of hospital leadership, medical staff, patients and their families, the community and other healthcare providers to deliver compassionate, high-quality, affordable healthcare.
- Promote justice and respect for those we serve.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility and accountability for every healthcare related decision and action.
- A focus on excellence, teamwork and innovation through continuous learning, improvement in system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The Patient Safety/Risk Management Program at St. Rose Dominican is an organization-wide/campus specific strategy that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety/Risk Management Program at Rose de Lima Campus supports and encourages the active participation of each person in order to be an effective program. When processes, functions or services are designed or redesigned, information internal and external to the campus and/or organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or services.

The purpose of this plan is to establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program Plan designed to promote and improve patient safety at Dignity Health – St. Rose Dominican, Rose de Lima Campus, by working to prevent medical/healthcare adverse events and reducing risk to patients and visitors.

Undesirable facility specific and system patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns or trends vary significantly and undesirably from those expected including significant near misses;
- Performance varies significantly and undesirable from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
 - Hospital acquired infections
 - Medication events, to include delays in administration
 - Adverse drug events
 - Transfusion reactions
 - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

Roles and Responsibilities

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

The Patient Safety Committee Organization

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;

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

The roles and responsibilities are defined below.

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

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Rose de Lima Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.

- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- See Quality Department's Performance Improvement Plan

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

The Manager of Risk Services has been designated the Patient Safety Officer for the Rose de Lima Campus and as such, has the administrative responsibility for the program specific responsibilities including:

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Day to day responsibility for the Patient Safety/Risk Management Program at Rose de Lima Campus.
- Maintenance of related data collected, trended and analyzed at each campus.
- Routine reporting to leadership and QCAC on campus specific trended data and actions taken to improve the quality and safety of patient care.
- Working with QCAC to achieve the goals of the Patient Safety/Risk Management Program.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.

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

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporates the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Identify RCA participants and coordinate a time, date and location of RCA meeting.
- Inform RCA participants of the sentinel event process.
- Explain confidential nature of RCA.
- Explain Just Culture and its application.
- Review event using medical record and any other pertinent materials in preparation for the RCA.
- Provide RCA members access to relevant best practice/research documents/statutes and other literature to include hospital Policy and Procedure documents for reference.
- Conduct RCA in a manner consistent with Just Culture, using principles of human factors, systems theory, etc.

Executive or Governing Body Staff Responsibilities

Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.

Leadership

The Dignity Health St. Rose Dominican Board and campus Senior Leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety/Risk Management Program. These responsibilities are campus specific and include the following:

- Foster an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.
- Establish a culture in which communication flows freely regardless of authority gradient.
- Ensure that a define, on-going, proactive program for identifying risks to patient safety and reducing medical/healthcare adverse events is fully implemented and includes responses to actual and potential events;
- Ensure that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Provide for mechanisms to measure, analyze and manage variation in the performance of defined processes that affect patient safety;
- Allocate adequate resources, including personnel, time, information systems data associated with reducing risk and improving patient safety, and
- Active participation in the California Hospital Patient Safety Organization (CHPSO).

Physicians

Physicians are responsible, as participants in the Patient Safety/Risk Management Program for reporting events or near misses at each campus, and participating on focus teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (LIP) or comparable designee shall clearly explain these outcomes to the patient, and when appropriate, the family. (See Disclosure Policy)

Patients/Families/Visitors

Patients, families and patient representatives via written communication are encouraged to be active participants in their care and as such are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to the patient's health;
- Reporting their patient and outcome of treatment of that pain
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner, and
- Asking questions when they do not understand what they have been told about the patient's care, infection control, safety precautions and programs or what they are expected to do etc.

Patients and families/patient representatives/visitors will be provided with educational materials explaining these expectations and their role in reducing risk exposure and improving patient safety at the time of admission and throughout the patient stay utilizing various delivery methods including pamphlets, television

and verbal communication. Some patients may also be included in the development process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

Hospital Departments and Staff

Rose de Lima staff are key to promoting, identifying, and implementing activities to reduce risk and improve patient safety. Some of the activities include:

- Active participation in the activities to improve patient safety and the quality of healthcare delivered;
- Adherence to Infection prevention measures, the Joint Commission National Patient Safety Goals and other patient safety initiatives;
- Participation in education activities and process implementations;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among caregivers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in information needs assessment, staff surveys, and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all events and process variances (harm or no harm) even if they do not reach the patient (near miss).

The Patient Safety Committee

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Rose de Lima Campus and includes multidisciplinary team members which have oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow up on patient safety related trends, analysis results, changes in processes, policies and other areas to make as a result of identified needs.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).

- Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Patient Safety/Risk Management Plan

Goal	Plan	Due Date
Risk Assessments	1. Patient Safety/Risk Management to perform monthly risk assessments and report to PSC. 2. Infection Prevention to report to PSC findings of Risk Assessments.	Monthly PSC
FMEA	PSC to ensure one FMEA is conducted by Risk Management in CY 2019.	December 2019
Checklists	PSC will receive all new and renewed checklists used that impact patient safety whether directly or indirectly.	Monthly and ongoing
National Patient Safety Goals	PSC will support the posting of NPSGs throughout the hospital for staff reference.	Department leaders
Root Cause Analysis	RCAs will be conducted by Risk and Quality Management as soon as possible/practical after an event per Dignity Health policy	Ongoing
Manager orientation	Quality Risk Services will review/update Manager orientation.	March 31, 2019
Grievance Management	Grievances will be reviewed by the Grievance Committee to ensure compliance with CMS CoPs.	Quarterly and ongoing.

Goal	Plan	Due Date
Staff and physician education	Patient Safety education will occur in various forms (e.g. Huddles, Department Meetings, Leadership Meetings, Posters) throughout the year.	Ongoing

Components and Methods

Proactive Risk Assessment Activities

The Patient Safety/Risk Management Department, in collaboration with the various facility committees including Infection Prevention, Quality Council and leadership will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk Assessment activities will include, but not be limited to the following:

- Patient Safety Risk Assessment evaluating known high risk processes/procedures that have associated risks,
- Review employee survey results to identify safety concerns,
- On-going risk assessments based on internal and external data, including sentinel event alerts,
- Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.
- Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of Rose de Lima campus,
- Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.
- Patient Satisfaction surveys will include a question determining how the patient/family thinks the individual facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.
- Infection Prevention Surveillance Program.
- Additional staff surveys may be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety, as well as the staff's willingness to report medical/healthcare events.

Event Reporting

Rose de Lima actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration and evaluation activities. As provided under the CHPSO (42 Code of Federal Regulations (CFR) Part 3 Section 3.20) the event report is considered a Patient Safety Work Product and as such is privileged and shall not be (1) subject to subpoena; (2) subject to discovery; (3) subject to disclosure and (4) admitted into evidence-provided such information is not subject to disclosure in certain criminal proceedings as described in regulation. (See Event Reporting and Management Policy).

- A. When an unplanned event/process variance occurs, the patient care provider will do the following:
 - a. Perform the necessary healthcare interventions to support the patient's clinical condition.
 - b. Perform the necessary interventions to contain the risks to others.
 - c. Notify the patient's attending physician.
 - d. Preserve any information related to the event including physical evidence. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Report and in the patients' medical record.

- e. Notify immediate supervisor of the event.
 - f. Submit electronically an Event Report form or handwritten Event Report form to Risk Management/Patient Safety Services.
- B. Identification of potential unsafe condition that may affect patient safety:
- a. Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
 - b. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention

- A. Patient safety related event reporting data within the scope of the Patient Safety Program and risk assessment results will be aggregated and presented routinely to various committees including but not limited to Medical Executive Committee (MEC), Medication Safety, Quality Council and Environment of Care for analysis and action. Based on analysis of this data and any actual or potential reviews, sentinel events and other internal and external data including TJC Sentinel Event Alerts, Dignity Health Shared Learnings, CHPSO trends, current literature, proactive action plan will be developed to include the following:
- a. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
 - b. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
 - c. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
 - d. Redesign of the process and /or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
 - e. Test and implement the redesign process;
 - f. Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and
 - g. Implementation of a strategy for maintaining the effectiveness of the process over time.
 - h. Events that do not require a Root Cause Analysis will have an incident review completed by Quality/Risk Services Department as soon as practicable of becoming aware of the event. The results will be forwarded to leadership for review.

Response to Reported Adverse/Sentinel Events

Reporting of events is an essential component of a Patient Safety/Risk Management program. Through its participation in the CHPSO; all related investigation of events will be securely conducted, collected and documented as Patient Safety Work Product (PSWP) to maintain confidentiality as defined in the Federal Regulation.

- A. Rose de Lima shall respond to all reported potential and actual adverse/sentinel events. (See Sentinel Event policy).
- B. Minimally, all adverse events will be analyzed utilizing a team of individuals including Risk Management/Patient Safety and Quality Departments, to conduct root cause analysis (RCA), incident review and/or a failure mode effects analysis (FMEA), implementation in action plan to reduce further risk to patients and establish measures of effectiveness.
- a. The following events always elicit an intense analysis:
 - i. Confirmed transfusion reactions

- ii. Significant adverse drug reactions
 - iii. Significant medication events and hazardous conditions
 - iv. Manor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
 - v. Significant adverse events associated with anesthesia use.
 - vi. Hospital acquired infections
 - vii. All events meeting the definition of Sentinel Events in the State of Nevada.
 - b. A root cause analysis is performed when a sentinel or State reportable event occurs.
 - c. An incident review is performed when a near miss or other event with significant areas for improvement are identified.
- C. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
- a. A “JUST CULTURE” approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
 - b. Involved staff should be involved in the RCA process.
 - c. The Department Manager will provide ongoing support to the staff member(s) as needed.
 - d. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

Education

A. Staff Education

- a. General orientation and other education and training programs as needed will emphasize specific job related aspects of patient safety and risk reduction strategies.
- b. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
 - i. An overview of the Patient Safety Program
 - ii. Overview of TJC National Patient Safety Goals
 - iii. Staff’s role and responsibilities in the Patient Safety/Risk Management Program
 - iv. Event reporting criteria and process
 - v. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care
 - vi. Examples of specific job related aspects of patient safety.
- c. Staff participating at a higher level of the Patient Safety/Risk Management Program will receive appropriate training necessary to understand and complete their assigned responsibilities.

B. Physician Education

- a. An overview of the Patient Safety/Risk Management Program will be provided to physicians at time of initial appointment and annually thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
- b. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

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

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



Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Rose de Lima Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

Once the problems are identified, a Fishbone Diagram will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Whys technique also can be used to drill down the problem and find the root causes.

Model for Improvement

Please refer to the Dignity Health – St. Rose Dominican Performance Improvement Plan.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Rose de Lima is using IVOS for tracking the sentinel events, healthcare infection data, and Midas for internal data collection.

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

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

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>

Approval of Patient Safety Plan

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

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

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

Patient Safety Program Reporting and Review

All patient safety work product (PSWP) submitted through the CHPSO will be collected in the Patient Safety Evaluation System (PSES) for collection, management and analysis of information pursuant to the Patient Safety and Quality Improvement Act of 2005 (42 U.S.C. 299 et seq.).

- A. Patient safety/Risk Management related data and information reports will be provided routinely to various committees as previously identified including but not limited to medical staff, Quality Council and QCAC.

- B. A summary report of data, other internal and external information, as well as all actions taken by various committees and/or specific patient safety related teams will be submitted to the QCAC and the MEC.
- C. Annually, the Patient Safety/Risk Management Plan will be evaluated for effectiveness and the program updated to reflect the results of risk assessments related to patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.
 - a. The review will be approved by QCAC.
 - b. Will be submitted to the Community Board for final review and approval.

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Reviewed/Approved:

Patient Safety Committee, January 2019

Quality Care Advisory Committee of the Board, January 2019

Community Board, January 2019

SOUTH LYON MEDICAL CENTER

PATIENT SAFETY COMMITTEE

SUBJECT: Patient Safety Plan

POLICY NO:

PAGE NO: 1 of 8

EFFECTIVE: 11/2002

REVISED:12/2017

CROSS: Medical Staff

APPROVED:

POLICY: South Lyon Medical Center Patient Safety Plan

PROCEDURE:

1. The Medical Staff, with the approval of the Governing Board shall develop and implement a Patient Safety Plan to encompass all facets of patient care at South Lyon Medical Center. This includes Acute Care, Long Term Care and Rural Health Clinics.
2. The Medical Staff will appoint and submit to the Governing Board for approval the implementation of a Patient Safety Committee which will comprise at a minimum: a physician, a nurse, pharmacist, governing board member and risk manager. This committee shall:
 - a. function under the authority of the Medical Staff
 - b. meet monthly
 - c. investigate, report and formulate corrective actions related to alleged sentinel events
 - d. review medical equipment/devices safety and maintenance inspections
 - e. review and recommend actions related to medication events
 - f. review and investigate patient care related incident reports
 - g. review, investigate and recommend corrective actions for near-miss events
 - h. additional tasks as assigned by the Medical Staff
3. The Administrator shall appoint a Patient Safety Officer whose responsibilities are outlined in the position description.
4. The Patient Safety Plan shall include but not limited to the following items:
 - I. General:
 - a. Patient Safety involves a variety of clinical and administrative activities that health care organizations undertake to identify, evaluate, and reduce the potential for harm to beneficiaries and to improve the quality of health care. Effective medical/health care error reduction requires an integral approach and a supportive environment, in which patients, their families, organization staff and leaders can identify, manage and learn from actual and potential risks.
 - b. A successful patient safety program facilitates non-punitive, interdisciplinary approach to decrease unanticipated adverse health care outcomes. The organizational focus is on continued learning about risks and mitigation strategies and reengineering systems/processes to reduce the chance of human error. South Lyon Medical Center (SLMC) fosters and

supports an organizational environment that recognizes and acknowledges potential risks to patient safety and the occurrence of medical/health care errors. The patient safety program encourages medical error reporting in order to identify system or process failures and to enhance improvement strategies.

II. South Lyon Medical Center (SLMC) Patient Safety Program

- a. The goal of the SLMC Patient Safety Program is to reduce the chance that the adverse effects of human error will harm patients. By creating and promoting a culture in which staff willingly report actual and near-miss patient safety related events without fear of disciplinary action, SLMC is encouraging these events to be freely identified. Once events have been identified, systems and processes can be analyzed and improved in order to prevent future recurrence. Improved systems and processes result in a safer patient care environment.
- b. SLMC Patient Safety Program focuses on system and process design rather than on the individual involved in a given patient safety related mishap. This paradigm is very different from that which prevails in the health care community at large. In the patient safety conscious culture, when an error occurs the response is not to ask “who”, but rather “why”. This new paradigm can exist in light of other organizational expectations associated with risk management, claims management and review of potentially compensable events (PCE) for which the facility may incur financial liability.
- c. All patient safety related reports require that an investigation be conducted to determine the cause(s) of the adverse event.
- d. A patient safety event that causes no patient harm requires no standard of care determination. However, any patient safety event that results in patient harm or potential patient harm, by definition, is a PCE. The patient safety officer will be notified of all PCE’s and these will be managed according to the established policies and procedures outlined in the Patient Safety Committee. Given the results of the investigation of the event, a Standard of Care determination will be required. Competency related information that arises through patient safety investigations will not be released outside of the Patient Safety Program except as noted in paragraph e below. The Patient Safety Program will consider process/system issues, while the Standard of Care determination reviews the individual’s performance.
- e. Although not a specific focus of the Patient Safety Program, concerns about a specific provider’s/professional’s competence may arise. Competence relates directly to an individual and, as such, requires an evaluation of the provider’s/professional’s performance, not an evaluation of the health care system. Competence will be addressed through the organization’s competence assessment, credentialing and privileging process. No individual competence related information will be released outside of the Patient Safety Program, except as noted in paragraph f below. If the competence assessment processes are determined to require review and improvement, such recommendations by the Patient Safety Committee and Medical Staff may be appropriate.
- f. The vast majority of errors are unintentional. No disciplinary action will be initiated against the individual(s) involved in an unintentional error. However, certain events, such as noted below, do warrant administrative, disciplinary or legal action. Should any of the following be discovered in the course of a patient safety event investigation, the Administrator and Medical Staff will be immediately informed of the circumstance and action taken beyond the scope of the Patient Safety Program:
 - 1) Criminal activity (e.g. assault and battery, etc)
 - 2) Intentional unsafe acts due to gross negligence or reckless behavior

- 3) Alleged patient abuse of any kind
- 4) Impairment due to medical and psychological conditions including alcohol or other drug abuse.

III. South Lyon Medical Center Patient Safety Function.

- a. Integration of all patient safety related issues and processes under the auspices of a single committee/ functional team. This reduces duplication of effort and enhances program efficiency.
- b. Patient Safety Committee.

- 1) Membership. Membership is outlined in NRS 439.875; 1) The infection control officer, 2) The patient safety officer, 3) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility. And 4) One member of the executive or governing body of the medical facility.
- 2) Chairperson. The chairperson shall be a nurse or physician.
- 3) Committee minutes/reports. The committee minutes/reports will summarize the organizations patient safety activities to include, as a minimum:
 - a. Analysis of all clinical and non-clinical reported events, trends and lessons learned.
 - b. Actions necessary for organizational process/systems improvements as appropriate.
 - c. Proactive patient safety error reduction activities.
 - d. Progress related to risk assessments, prospective analysis and root cause analysis action plan implementation and effectiveness, according to established time lines.
 - e. Patient Safety Committee minutes/reports will be forwarded to the Medical Staff Committee. Quarterly reports will be forwarded to the Governing Board. Recommendations associated to patient safety will be forwarded to the Medical Staff for implementation as appropriate.

c. Management of Patient Safety Information.

- a. The focus of patient safety data collection and reporting is to improve organizational systems and to provide the safest care possible. The information and data amassed through reporting, investigation and evaluation will be confidential and reported through the Medical Staff Quality Assurance process.
- b. Data trend analysis will include, but not be limited to, the following:
 - 1) Sentinel Events or actual or alleged.
 - 2) Medication errors and fall.
 - 3) Equipment malfunctions.
 - 4) Preventive/corrective interventions
- c. Ad hoc committees may be assigned by the Medical Staff regarding competency investigations related to a patient safety related event to insure that peer status is maintained throughout any investigation. All information obtained will remain confidential under the auspices of Medical Staff Quality Assurance.

IV. Patient Safety Event Management.

- a. Event identification. A patient safety event is any incident that occurred (actual event) or almost occurred (near miss) that caused or had the potential to cause harm to a patient. Identification and reporting of near misses and adverse events, including those that result from practitioner/professional error, should be encouraged as an expectation of everyday practice. The three types of patient safety events include near miss, adverse events and sentinel events.
- b. Near Miss. A near miss is an event or situation that could have resulted in harm to a patient, but did not, either by chance or through timely intervention. The event was identified and resolved before reaching the patient. Because near misses generally occur more frequently than actual adverse events, proactive analyses of near misses provide a tangible opportunity to improve the system without having to experience an actual adverse event. Staff should be encouraged to report near miss events for the purpose of analysis and identification of methods improvement.
- c. Adverse Event. An adverse event is an occurrence associated with the provision of health care or services that may or may not result in harm to the patient. Adverse events may be due to acts of commission or omission. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no harm or permanent effect to the patient.
- d. Sentinel Event. A sentinel event is an unexpected occurrence involving death, serious physical or psychological injury, or the risk thereof. **Recent Nevada Legislation has expanded the definition of a Sentinel Event to include Surgical Site Infections (SSI's), Catheter Associated Urinary Tract Infections (CAUTI's). A comprehensive listing of potential Sentinel Events is included in the Sentinel Event Reporting Guidance Compliance Manual dated 12/06/2011. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and proactive response on the part of the organization.**

V. Event Documentation and Reporting.

1. Prevention of harm to patients is everyone's responsibility and reporting all potential and/or actual patient safety events is a performance expectation of all organizational staff. Anyone with knowledge of a patient safety event not only may, but should, report it.
 - a. Immediate actions.
 - 1) Upon identification of a actual patient safety event, the staff member will immediately perform necessary health care interventions to protect and support the patient's clinical condition. The patient's attending physician and other physicians, as appropriate, will be contacted as soon as possible to report the incident and provide an update on the patient's current clinical status.
 - 2) As appropriate to the event, the staff will initiate all physician directed orders and take other necessary health care interventions to contain the risk to others, and to preserve event-related materials that may require further investigation. Examples of physical information preservation include: removal and preservation of a blood unit for a

suspected transfusion reaction; preservation of IV tubing, fluid bag, and/or IV pump for a patient with a severe drug reaction from a IV medication. Preservation of information also includes documenting the facts regarding the event in the patient's medical record according to organizational policy and procedure.

- 3) If the patient safety event involves serious physical or psychological injury, unexpected death, or qualifies as a sentinel event, the appropriate department director will be notified immediately. If such events occur after hours, the administrative on-call staff will be notified immediately. Individuals notified will ensure proper notification of senior management is accomplished in a timely fashion.

b. Documentation and Internal Reporting.

- 1) Any individual in any department who identifies a potential (e.g. near-miss) or actual patient safety event will immediately notify their immediate supervisor and will initiate a Incident Report. This report will contain concise, factual, objective and complete details about the event.
- 2) Incident Reports or in the case of medication errors, a Adverse Drug Event Report will be forwarded to the department director within 24 hours of the discovery of the event or the first duty day following a weekend or holiday. The department director will review the report, add any additional relevant information, and forward it to the Patient Safety Officer, or designee, within 24 hours of receipt.
- 3) The Patient Safety Officer (PSO), or designee, will review all incident reports and ADE reports. In addition, the PSO will determine what specific actions are necessary to further evaluate the event. If the event is a sentinel event, the PSO will immediately notify the Administrator and Risk Manager and activate a Root Cause Analysis Team from the Patient Safety Committee and others as deemed appropriate to investigate the event.
- 4) If the patient safety event is an intentional unsafe act that results from gross negligence or possible criminal activity, the event shall be reported to the appropriate authorities for investigation.
- 5) Some events fall within the definition of both an adverse event and an intentional unsafe act. For example, infant abduction would be both a crime and a reportable Sentinel Event that require Root Cause Analysis. In cases that appear to be both a adverse event and an intentional unsafe act, primary authority and responsibility for dealing with the event belongs to the Administrator and Risk Manager. This is beyond the scope of the Patient Safety Program. The PSO will coordinate a review of the systems and processes implicated in the actual or potential unsafe act, to include conducting a root cause analysis, if applicable, but will defer to a separate investigation with respect to the culpability of any persons involved in the event.
- 6) External reporting requirements. All incidents meeting the definition of a Sentinel Event must be reported to the State Health Department

and Bureau of Licensure. Reports must be completed within the time frame as outlined in policy and procedure.

VI. Patient Safety Event Analysis.

Event analysis assists in the discovery of the root causes and/or contributing factors associated with the patient safety event. Tracking and trending of data allows the Patient Safety Committee and Medical Staff to identify familiar trends or circumstances so that system or process issues can be identified and improved.

- a. Aggregate review analyses. Aggregate review consists of examining data elements for common trends or patterns within the group. The use of aggregated review serves two purposes. It allows for wider applicability of the analyses (i.e., trends or patterns that were not noticeable in an individual case analysis become more obvious as the number of cases increases). In addition, it more clearly defines specific data elements in a recurring problem and encourages prudent use of the time and expertise of the organization staff associated with evaluation and corrective action.
- b. Root Cause Analysis. A root cause analysis must be conducted and an action plan completed for all actual sentinel events. The Patient Safety Committee will formally designate a root cause analysis team to conduct a thorough and credible root cause analysis on all sentinel events. A Root Cause Analysis (RCA) is the process for identifying the basic and/or contributing casual factor(s) associated with patient safety events. The review is interdisciplinary and includes those who are closest to the process, but typically not those directly involved in the specific event. Those directly involved may be consulted for event-related information if appropriate. The RCA focuses on systems and processes, not individual performance. It identifies changes that could be made in the systems and processes to improve performance and to reduce the risk of adverse events, or the recurrence of near misses, with the ultimate goal of reducing and/or eliminating patient harm.
- c. Root Cause Analysis Action Plan. Once the RCA has been completed, a detailed action plan must be developed to enumerate the risk reduction strategies that the organization intends to implement to prevent the recurrence of similar events. The action plan should address responsibility for implementation, oversight, pilot testing (if appropriate), timeliness, and the specific metrics to be employed in evaluating the effectiveness of the actions taken.
- d. The RCA action plan will be submitted to the Medical Staff for approval.
- e. Follow-up review. All RCA action plans will be reviewed at a minimum of 6 months following implementation to address the effectiveness of the improvements implemented by the organization. These findings will be reported to the Medical Staff and Governing Board.

VII. Patient Safety Event Communication.

Administration and all staff are reminded that all data compiled as part of the Patient Safety Program are QA information and protected from disclosure and must be marked as Quality Assurance Document.

- a. Staff involved in a patient safety event. Any staff member reporting and/or directly involved in a patient safety event that caused patient harm will receive support and assistance from their supervisor to facilitate the staff member's professional and emotional needs related to the patient safety event. Management efforts and activities will focus on improving the systems and processes that may have contributed to the event rather than disciplining those involved.
- b. Reporting a patient safety event. Staff members and supervisors who submit patient safety event reports will receive timely feedback on the actions being taken as a result of their report.
- c. Patient/family affected by a patient safety event. In cases involving an unanticipated outcome of care, a qualified health care provider will inform the patient and/or his/her family member(s) within seven (7) days of discovery of the event. This information is provided as a matter of policy and does not affect any rights or obligations in legal or administrative proceedings. Under no circumstances will QA-protected information be released or provided to the patient/family member.
- d. The Patient Safety Officer, or designee, is responsible to ensure that the provider and patient/family member communication takes place. The designated primary communicator will document in the patient's medical record what was communicated to the patient/family member, the patient/family member's response, and any other pertinent information. It shall be the responsibility of the affected patient's primary care physician or Chief of the Medical Staff or Vice Chief of the Medical Staff to make the initial and subsequent notification.
- e. In most cases, facts surrounding the patient safety event that affect the patient can and should be disclosed to the patient/family member by the provider.
- f. Any specific questions relative to disclosure of information associated with unanticipated adverse outcomes should be referred to the organization's legal representatives.

VIII Patient safety Education and Training

- a. All staff shall receive patient safety education and training during their initial new employee orientation and on an annual and as-needed basis, regarding job-related aspects of patient safety and staff specific roles and responsibilities to actively support patient safety policy.
- b. Community education. Patients and potential patients/family members shall be educated concerning their role in helping to facilitate the safe delivery of care. Methods include but are not limited to; public forums, newspaper articles, addressing specific community groups and organizations.
- c. **Checklists have been developed and implemented in several different formats that range from facility policies, department checklists and medical record audits. These checklists and policies include but are not limited to; correct patient identification and verification, foley catheter criteria, informing patients of Healthcare Acquired Infections (HAI's) or Facility Acquired Infections (FAI's), hospital inpatient information sheets related to HAI's and hand hygiene and respiratory etiquette and patient information regarding discharge planning, medication reconciliation and request that providers indicate the use or reason for each prescription that is issued.**
 - a. **On or before July 1 of each year a report will be submitted to the Director of the Legislative Counsel Bureau which includes the**

development, revision and usage of patient safety checklists and policies.

IX Confidentiality of Medical Quality Assurance Information.

As with other medical QA documents, any information, records, reports, minutes, and other documents directly associated with patient safety activities are protected under 10 USC 1102. In discussing medical information with family members, staff shall also comply with other applicable restrictions on nonconsensual disclosures, including those under the Privacy Act, 5 USC 552a. As a general rule under the Privacy Act, information regarding a patient's condition shall not be provided to others without the patient's consent.

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

QUALITY AND PATIENT SAFETY PLAN 2019

SNAMHS

DATE: 02/15/2019

VERSION: 01



DPBH Mission Statement

It is the mission of the Division of Public and Behavioral Health to protect, promote and improve the physical and behavioral health of the people of Nevada.

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

**Patient Safety Committee/Program
Rawson-Neal Hospital**

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Las Vegas, NV 89146

Frances Twigg, Rawson-Neal Patient Safety Officer
SNAMHS Patient Safety Committee Chair

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Contents

Commitment to Patient Safety.....	3
Mission, Vision, and Values.....	3
Scope and Purpose.....	3
Roles and Responsibilities.....	Error!
Bookmark not defined.	4
Exexcutive or Governing Body Staff Responsibilites.....	5
Patient Safety Committee_Roles and Responsibilities.....	5
Patient_Safety Officer Responsibilities.....	6
Infrection Contol Officer Responsibilities.....	6
RCA Facilitator Responsibilities.....	7
RCA Team Responsibilities.....	7
Objectives and Goals of the Quality and Patient Safety Plan.....	8
Root Cause Analysis.....	10
Model for Improvement.....	11
Data Collection and Reporting.....	12
Assessment of the Quality and Patient Safety Plan.....	13
Patient Safety Checklists and Patient Safety Policies.....	14
Approval of Patient Safety Plan.....	16
Reference.....	16
Appendix A: Terms and Definitions.....	17
Appendix B: Patient Safety Goals.....	19
Appendix C: Fishbone Diagram.....	20
Appendix D-1: PDSA Worksheet.....	21
Appendix D-2: PDSA Monthly / Quarterly Progress Report.....	23
Appendix E: Checklist Example: Injuries from Falls and Immobility.....	24
Appendix F: Policy Example.....	25

Commitment to Patient Safety

SNAMHS is committed to becoming a high reliable organization through a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values,

creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes being “aware that safety is an emergent not a static property” (Patient Safety Primer High Reliability November 2017).

Mission, Vision, and Values

In support of our mission, vision, and values, SNAMHS Patient Safety and Quality Improvement programs promote:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

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

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

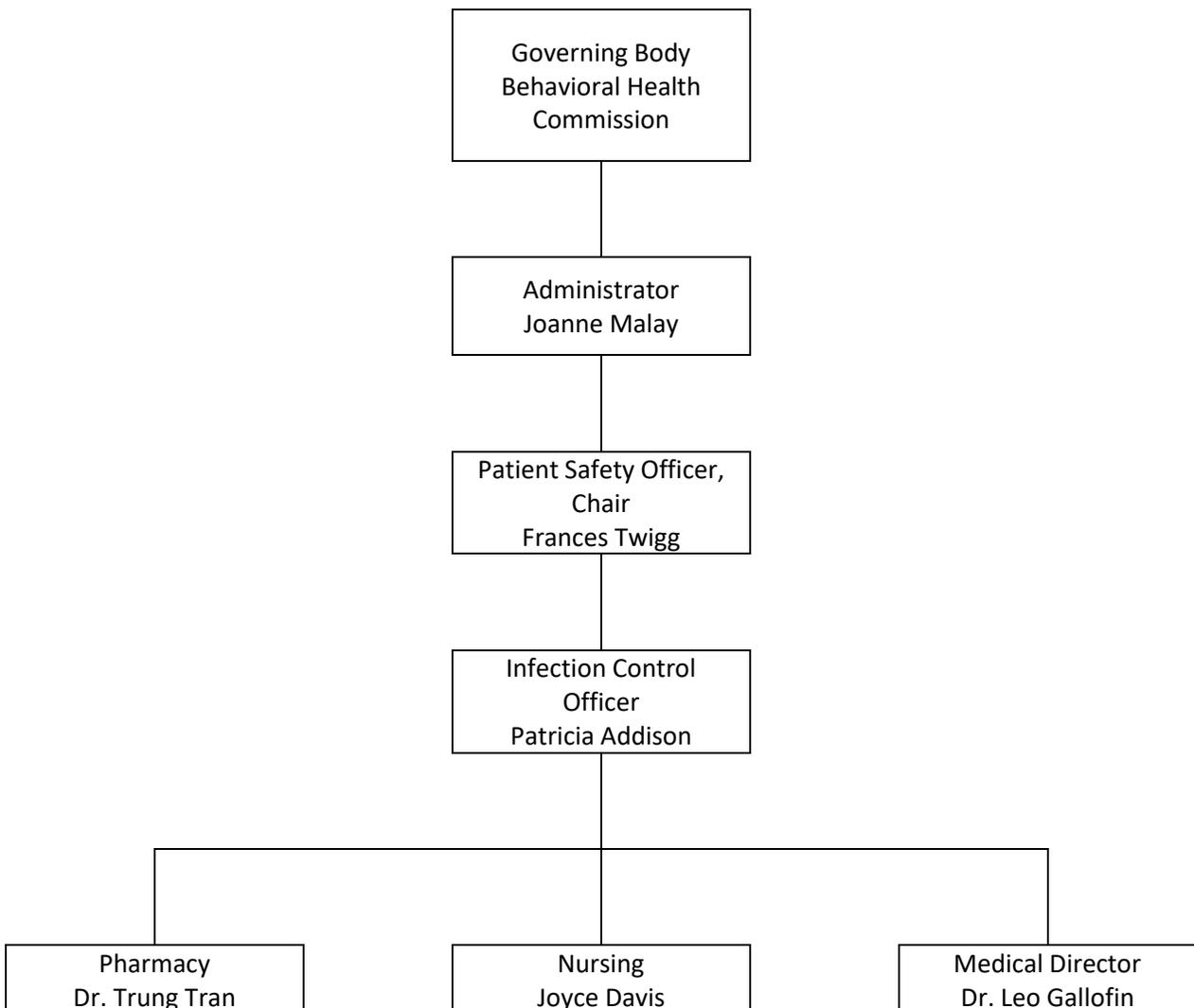
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

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

Roles and Responsibilities

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

The Patient Safety Committee Organization



The roles and responsibilities are defined below.

Executive or Governing Body Staff Responsibilities

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

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
 - The infection control officer of the medical facility;
 - The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
 - At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
 - One member of the executive or governing body of the medical facility.
- Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:
 - The patient safety officer of the medical facility;
 - At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
 - The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

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

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer regarding all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.

- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Participate as a consultant to the RCA teams
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.
- Complete and submit the NSHN report to the state Registry and the CDC

The Patient Safety Committee will meet monthly to accomplish the following:

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

RCA Facilitator Responsibilities

- Organize and coordinate the RCA as well as facilitate the RCA process
- Identify team members and alert their supervisors, as well as the staffing department to provide coverage on their units or department
- Assemble and encourage a supportive and proactive team. Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

An RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
 - Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
 - Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
-
- Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.

- Developing strategies, solutions, and steps to take next.
- **Identify barriers and technical assistance needs for supporting the RCA efforts.**

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Revise unit monitor board to include Violence Risk Behavior indicators and interventions utilized to prevent violence	Reduce seclusion or restraints by 10 %	<ul style="list-style-type: none"> ● Monitor compliance with training. ● Audit charts for proper documentation of Audit all seclusion and restraints monthly tracking days, time, unit length of event and clients with multiple events 	6/30/19 12/31/19 12/31/19	Restraint Free Committee Restraint Free Committee Patient Safety Officer
Implement CPI (Crisis Intervention Institute) training to all direct care staff.	Enable staff to be more equipped in dealing with crisis intervention with ultimate goal to decrease restraint events by 10 %	Begin 2/21/19 Training all direct Care staff as a priority and follow with indirect care staff	12/31/19 Pending	Training Department
Objective	Goals	Plan	Planned Completion Date	Responsible Party
Increase staff compliance for seasonal flu vaccines by 10% yearly. Current compliance	100 % staff compliance rates for Flu vaccines	<ul style="list-style-type: none"> ● Determine root cause for low compliance rate ● Promotion of strict policy enforcement and clear analogies for denials ● Determine why 	July 1, 2020	Infection Control Infection Control Infection Control

rate is 74%		<p>supervisors are not actively involved in making sure their employees are compliant with flu requirements each season</p> <ul style="list-style-type: none"> • Campaign and thoroughly educate staff, cooperate and individually who decline Flu vaccination. Enforce flu masking policy for those who decline the flu vaccination. 		<p>Infection Control</p> <p>Infection Control</p> <p>Administration/Chief Medical Officer/Director of Nursing</p>

Components and Methods

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

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

-



Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Rawson-Neal to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

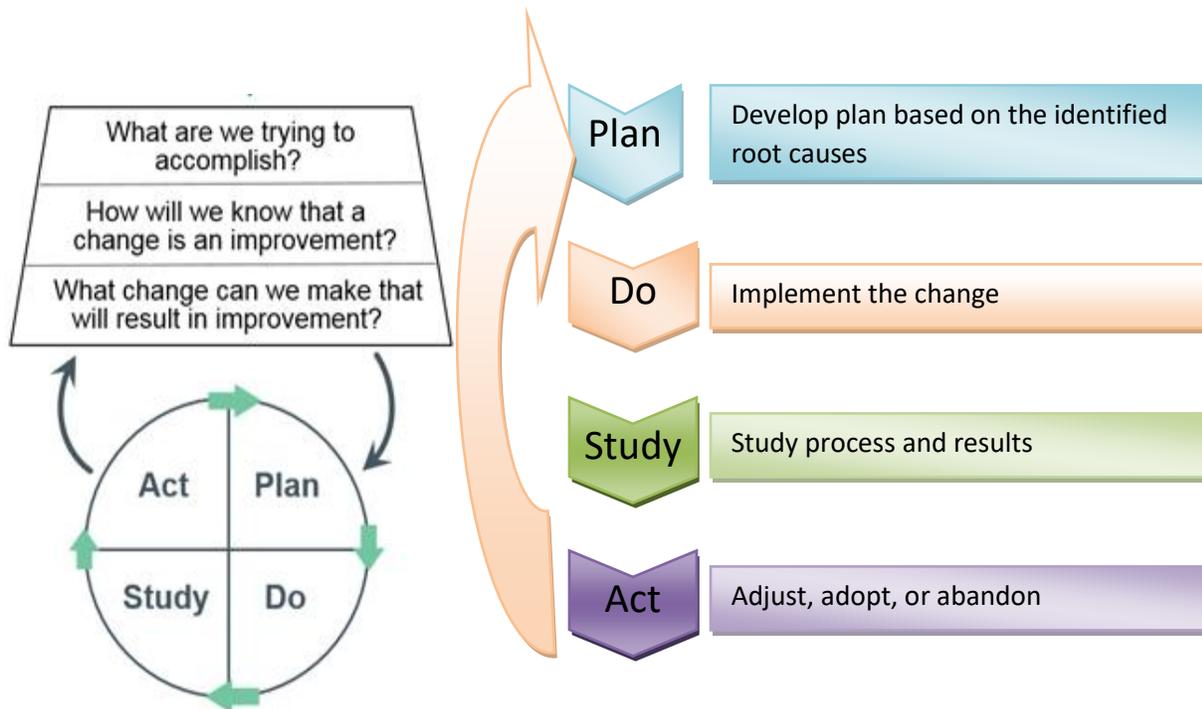
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. SNAMHS is using Avatar for tracking the sentinel events, healthcare infection data and seclusion and restraint data.

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

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



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA Report 4) Seclusion and Restraint events monthly report	1) Sentinel event quarterly report 2) Review and evaluate the measurement to prevent and control infections 3) Review and evaluate the plans of correction for RCAs within each quarter 4) Review and evaluate data trending in seclusion and restraint episodes	1) Yearly Quality and Patient Safety Plan update, due March 1, 2018 2) Yearly Sentinel Event Report, due March 1, 2018 2) Yearly AB280 report (Checklists and Policies reviewing and revising) due July 1, 2018

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility (NRS 439.805)

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

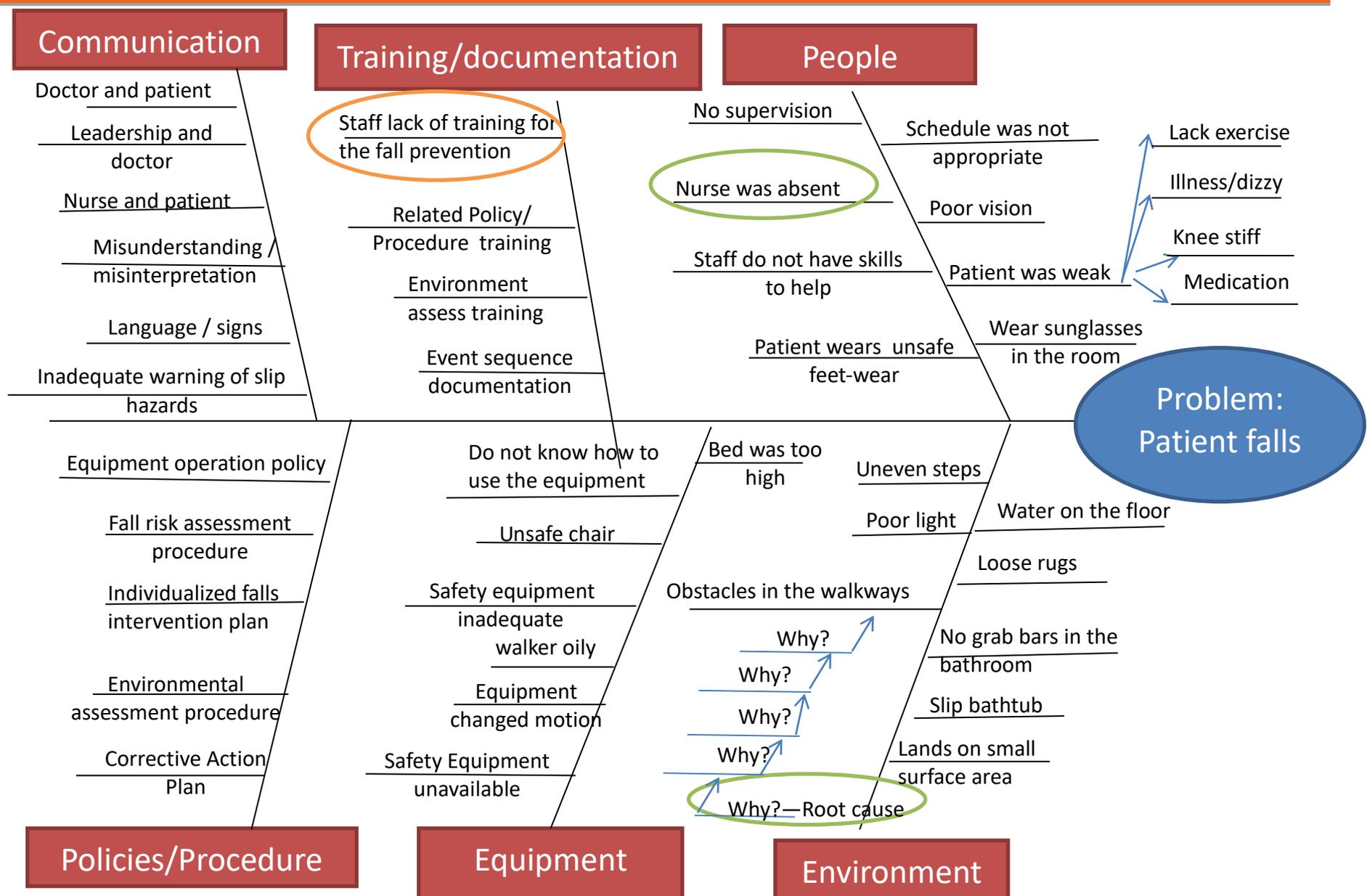
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
		Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS. Increase number of events reported by 10%. Create process for communicating outcome of reported events.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.			
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey.	Establish & implement a plan to improve performance of each leap.	Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.
		Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.		Establish Patient Safety Council.	
			Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	
<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks (vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>07/01 08/14 08/17 Policy Committee</p>

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

SUMMERLIN HOSPITAL MEDICAL CENTER

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2019

I. Overview

SUMMERLIN HOSPITAL MEDICAL CENTER endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients. Patient safety is a cornerstone of quality care and is a leadership priority. **SUMMERLIN HOSPITAL MEDICAL CENTER** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **SUMMERLIN HOSPITAL MEDICAL CENTER** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **SUMMERLIN HOSPITAL MEDICAL CENTER** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **SUMMERLIN HOSPITAL MEDICAL CENTER**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **SUMMERLIN HOSPITAL MEDICAL CENTER** policies. **SUMMERLIN HOSPITAL MEDICAL CENTER** employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

SUMMERLIN HOSPITAL MEDICAL CENTER mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

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

SUMMERLIN HOSPITAL MEDICAL CENTER recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

SUMMERLIN HOSPITAL MEDICAL CENTER has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective

facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

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

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

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

SUMMERLIN HOSPITAL MEDICAL CENTER has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **SUMMERLIN HOSPITAL MEDICAL CENTER** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

SUMMERLIN HOSPITAL MEDICAL CENTER PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.

- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

SUMMERLIN HOSPITAL MEDICAL CENTER is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the

Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. Risk Connect (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

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

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. UHSD Acute Care Division Patient Safety Priorities, Goals and Objectives for 2019

- **Surgical and Procedural Safety:**
 - **Wrong Site Surgery.**

- 5% reduction of 2019 Violence related harm events. Increase utilization of security assists with subsequent decrease in security emergency utilization which will further impact harm events.
 - Monitor through Midas EOC Dashboard, Loss Control Reports, Serious Incident debriefing and HealthStream training modules. Report quarterly with oversight by PSC.
- **CLABSI/CAUTI Initiative**
 - **Goal:** CLABSI and CAUTI rates will be reduced by 10% each in 2019.
 - Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly with oversight by PSC.
- **Executive Engagement in Safety/Safety Huddles**
 - **Goal:** 100% of essential safety huddle elements will be included in all hospital unit/department and Executive Safety Huddles.
 - Monitor through Observation/Mentoring Forms completed by Patient Safety Leads and Corporate resources. Report monthly with oversight by PSC.
- **Safe Medication Use**
 - **Emergency Department Pyxis Optimization**
 - **Goal:**
 - Identify those limited emergency departments with ADCs that are not in profile mode.
 - Assess the barriers to converting those ADCs to profile mode and create a timeline for conversion by mid-Q1 2019.
 - Convert 100% of ADCs in the emergency departments to profile by Q2 2019.
 - Decrease the number of all-harm, medication events related to ADC overrides by 10% by December 2019.
 - Monitor through MIDAS reports, trigger tools, Cerner orders, and other intervention data. Report monthly with oversight by PSC.
 - **Opioid Analgesic Event Reduction Initiative**
 - **Goal:** decrease the number of adverse drug events related to opioids by 10% by the end of 2019.
 - Monitor through Cerner, MIDAS, ICD-10 codes, and intervention data. Report monthly with oversight by PSC.
 - **High Alert Medication Error Reduction**
 - **Goal:** 10% error reduction goal with warfarin and insulin medication administration errors.

- Monitor through MIDAS, Cerner, PSO reports, Pharmacist Interventions. Report monthly with oversight by PSC.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls in the acute division by end of 2019.
 - Monitor through MIDAS event reporting. Report quarterly with oversight by CPSC.
- **Risk Rounding with Purpose**
 - **Goal:** Risk Department will round on each unit/department at least twice a month with a focus on MIDAS reporting
 - Monitor through rounding checklist and report at the PSC monthly.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program

consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

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

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

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

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;

- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at

http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Patient Safety Committee and Reporting

Patient Safety is the responsibility of all employees and Medical Staff members. The Patient Safety Program will be multi-faceted and that responsibility will be shared among several individuals, groups, and teams. Each performance improvement team is multidisciplinary in nature with representatives from the hospital and medical staff. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement teams are sent to the Quality Council and reported to the Medical Executive Committee and the Governing Board.

In compliance with State of Nevada Regulations, the Patient Safety Committee will be comprised of:

- (1) The patient safety officer of the medical facility.
- (2) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.
- (3) One member of the executive or governing body of the medical facility.

The Patient Safety Committee is also multidisciplinary with representation from the following areas: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management, and the Hospital's Infection Control Preventionist.

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:
 - a. Risk and Safety Management
 - b. External Data Reports
 - c. Sentinel Event Alerts from the Joint Commission
 - d. Healthcare Reports
 - e. Regulatory Reports
 - f. Patient/Family Members
2. Continually improve processes of care delivery based on data analysis.
3. Develop policies and procedures that result from process improvement activities.
4. Develop and approve Patient Safety Education for the medical and hospital staff.
5. Conduct an annual risk assessment of patient safety issues/strategies from internal and external reports.

The Hospitals believe in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator/CEO.

The activities of the Patient Safety Program and an annual review of the Patient Safety Plan, appropriate policies, forms, checklists and best practices will be reported to the Patient Safety Committee, the Medical Executive Committee, and the Governing Board as outlined in the Performance Improvement Plan and the LifeCare Reporting Calendar. Communication within the hospital and medical staff is the key to a successful patient safety program and will be encouraged.

Education and training is an important and effective tool in assuring that the Patient Safety Program is clearly understood, particularly error identification and reporting and the basic approaches to Patient Safety. Education and training on patient safety is included in new employee general and department orientation and reviewed annually. Additionally, education will be provided to patients and their families about their role in helping to facilitate the safe delivery of care.

Please revise and expand this template to meet your facility's needs.

**Facility Name: Kindred Hospital Las Vegas Sahara
Campus**

QUALITY AND PATIENT SAFETY PLAN Template

DATE:

~~01/01/2017~~ 02/19/18 ~~MM/DD/~~



This plan was created and revised by the Kindred Hospital Las Vegas Sahara Campus ~~(facility name)~~ Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

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Patient Safety Committee/Program
Kindred Hospital Las Vegas Sahara Campus ~~Facility name:~~
5110 West Sahara Avenue
Las Vegas, Nevada 89146

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Kyle Reeves RN ATC Traci Allen
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702 790 352 93520827

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702 790 0855352 9450

Estrella Sutton RN BSN MBA
Chief Clinical Officer
702 790 0801352 9420

Facility Address

Facility contact information

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Contents

Commitment to Patient Safety.....322

 Mission, Vision, and Values323

Scope and Purpose.....423

Roles and Responsibilities.....444

 Roles and Responsibilities5

Objectives and Goals of the Quality and Patient Safety Plan888

Components and Methods1088

 Root Cause Analysis.....1199

 Model for Improvement121010

 Data Collection and Reporting.....141111

Assessment of the Quality and Patient Safety Plan151212

Patient Safety Checklists and Patient Safety Policies151313

Approval of Patient Safety Plan171515

Reference.....171515

Appendix A: Terms and Definitions181616

Appendix B: Patient Safety Goals211818

Appendix C: Fishbone Diagram.....221919

Appendix D-1: PDSA Worksheet.....232020

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Appendix D-2: PDSA Monthly / Quarterly Progress Report 252222

Appendix E: Checklist Example: Injuries from Falls and Immobility 262323

Appendix F: Policy Example 272424

Commitment to Patient Safety

Kindred Hospital Las Vegas Sahara Campus (Facility name) is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

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Mission, Vision, and Values

In support of our mission, vision, and values, Kindred Hospital Las Vegas Sahara Campus's Patient Safety and Quality Improvement program promotes:

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

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Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in (facility name Kindred Hospital Las Vegas Sahara Campus) are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

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This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, (facility name Kindred Hospital Las Vegas Sahara Campus) has developed this Patient Safety Plan.

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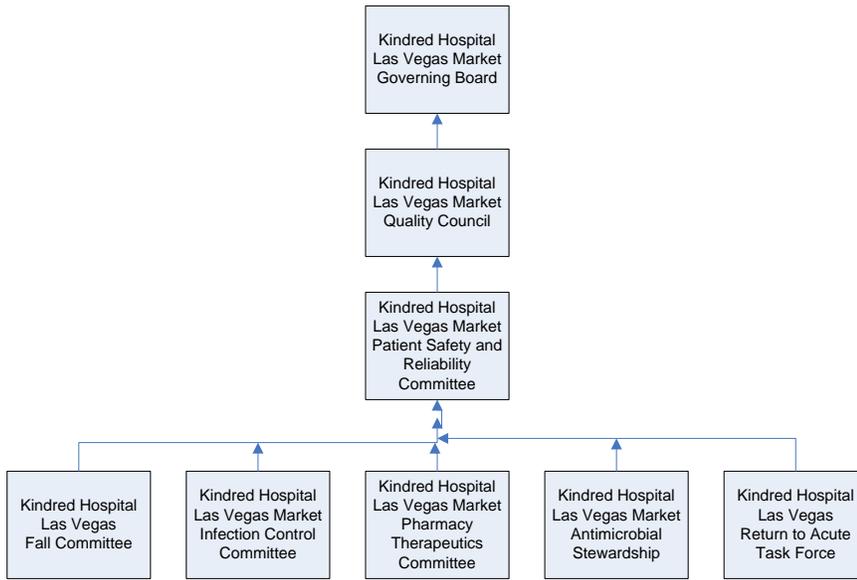
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

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

Roles and Responsibilities

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

The Patient Safety Committee Organization



R

Roles and Responsibilities

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

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

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

The roles and responsibilities are defined below (Please modify them as needed.)

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

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

Root Cause Analysis (RCA) Team Responsibilities ~~(please revise as needed)~~

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

~~(Additional responsibilities here if needed)~~

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Infection Control Officer Responsibilities (based on [NRS 439.873](#))

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

~~—(Additional responsibilities here if needed)~~

RCA Team Leader Responsibilities ~~(please revise as needed)~~

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Provide vision and leadership to the Root Cause Analysis process
- Work with the Director of Quality Management to assure process changes are implemented
- Guide the staff in the process of discovery and mitigation of future process failures

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~~(Please provide the responsibilities here)~~

Executive or Governing Body Staff Responsibilities ~~(please revise as needed)~~

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

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~~(Please provide additional responsibilities here if needed)~~

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

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
<u>CLABSI Reduction</u>	<u>Reduce CLABSI by 150%</u>	<ol style="list-style-type: none"> 1) <u>Use Tegaderm Dressings</u> Update the education for new dressing kit 2) <u>CHG Bathing Program</u> 3) <u>Staff education and competencies on hire and annually thereafter</u> 	<u>1st Quarter 2017/12/31/18</u>	<u>ICP/CCO</u>

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		<ol style="list-style-type: none"> 4) <u>Develop nurse-driven protocol for discontinuation of lines</u> 5) <u>RCA performed for each event</u> 		
<u>CAUTI Prevention</u>	<u>Reduce CAUTI by 10%</u>	<p>Skills laboratory for peri care, foley care and cath secure.</p> <ol style="list-style-type: none"> 1) <u>Staff education and competencies on hire and annually thereafter</u> 2) <u>Competency based demonstration. Evaluate use of external female urine systems</u> 3) <u>RCA performed for each event</u> 	<u>1st Quarter 2017/12/31/18</u>	<u>ICP/CCO</u>
<u>HANOWPU Prevention</u>	<u>Reduce HANOWPU by 10%</u>	<ol style="list-style-type: none"> 1) <u>Use of Patient Safety Index to assure HAPU prevention</u> 2) <u>Braden Scale, Repositioning, Assessment and Wound Education to Patient Family Score</u> 3) <u>RCA done for each event</u> 	<u>Quarterly Assessment 12/31/18</u>	<u>Wound Care Coordinator/ Chief Clinical Officer</u>
<u>Employee Health</u>	<u>Improve flu vaccine by 5%</u>	<ol style="list-style-type: none"> 1) <u>Vaccine Education</u> 2) <u>Use of isolation masks by non-vaccinated personnel in clinical areas</u> 	<u>3rd Quarter 2017/12/31/18</u>	<u>Employee Health Nurse/ Chief Clinical Officer</u>
<u>Antimicrobial Stewardship</u>	<u>Reduce Antibiotic usage to < 35% of total drug cost use of unnecessary antibiotic therapies</u>	<ol style="list-style-type: none"> 1) <u>Enhance the Patient Safety Dashboard for Antimicrobial Therapy Use</u> 2) <u>Incorporate the Pharmacist/ICP/ Infectious Disease MD rounding</u> 	<u>2nd Quarter 2017/12/31/18</u>	<u>Director Pharmacy/ICP/CCO/ID Medical Director</u>

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		<p>— Staff, physician and Leadership Education Enhance the Patient Safety Dashboard for Antimicrobial Therapy Use</p> <p>— Incorporate the Pharmacist/ICP/ Infectious Disease MD rounding</p> <p>3) Staff and Leadership Education done 4th Quarter 20016</p>		
<u>Fall Reduction</u>	<u>Reduce falls by 10%</u>	<p>1) <u>Fall risk assessment completed for each patient, each shift</u></p> <p>2) <u>Re-implement Market Fall Reduction Performance Improvement Team</u></p> <p>3) <u>Staff education on hire and annually thereafter</u></p> <p>4) <u>Post-fall assessment completed for each event</u></p>	<u>12/31/18</u>	<u>DQM/CCO</u>

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Components and Methods

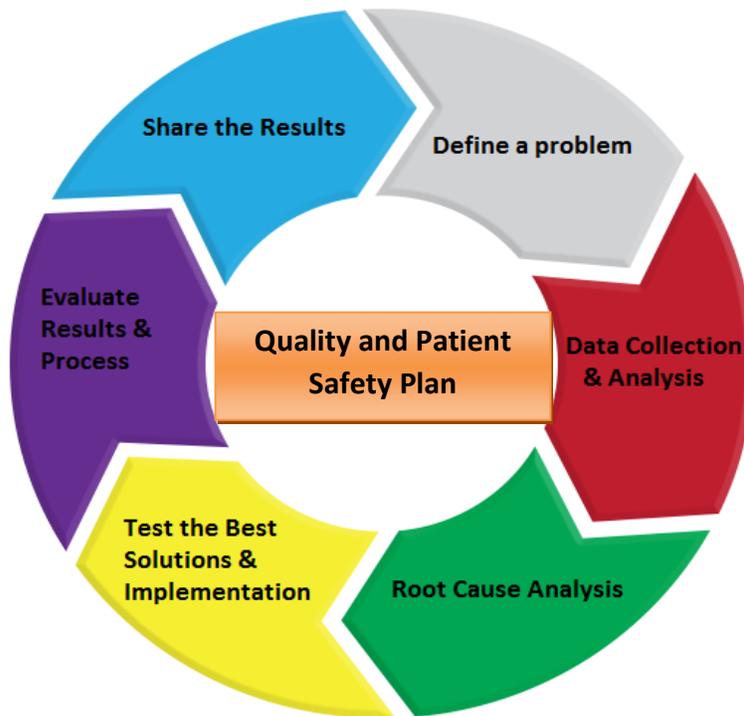
Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the

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sentinel event.”

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

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Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

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5 Whys technique will be used in (facility name Kindred Hospital Las Vegas Sahara Campus) to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

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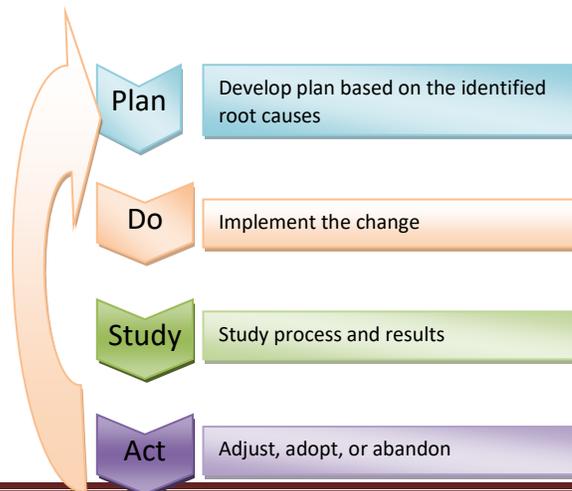
Fishbone Diagram

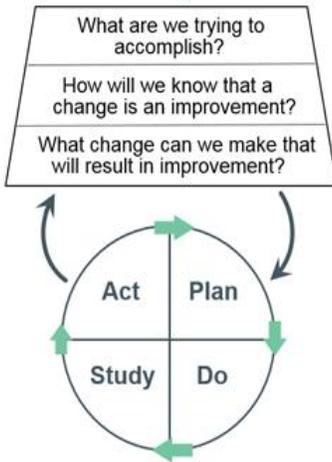
Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why's technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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





The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

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PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. (Facility name Kindred Hospital Las Vegas Sahara Campus) is using the Kindred Event Reporting System (Protocol) (data system names) for tracking the incident and sentinel events, NHSN for reporting healthcare infection data, WebIZ for reporting vaccinations and (any other database) Infection Prevention IPAC Administrator, and the, and Business Warehouse and Meditech Kindred Hospital DI for internal data collection.

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

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



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
---------	-----------	----------

1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising
--	--	--

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

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

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

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

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html

- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.” http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal

penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

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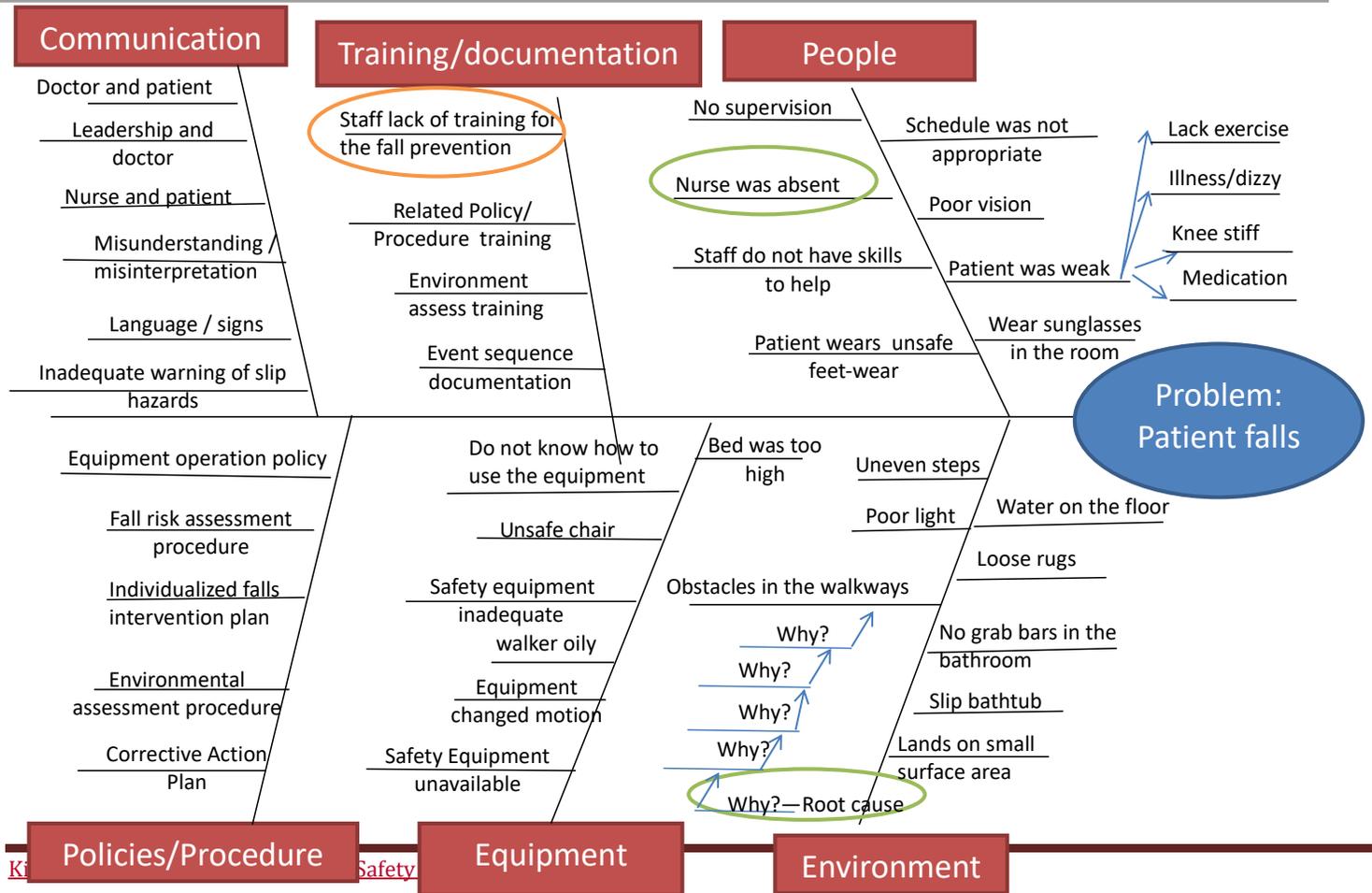
Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
		Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS. Increase number of events reported by 10%. Create process for communicating outcome of reported events.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
		Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans.	Establish & implement a plan to improve performance of each leap.	
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication		Establish Patient Safety Council.	
		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.			

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram

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Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:	
Person Completing Worksheet:	Date:
Telephone/ Email:	Cycle:
Patient Safety Committee Members	
CEOs/CFOs	
Patient Safety Officer	
Infection Control Officer	
Other Medical Staff	
Other team members	
Aim: (Describe the overall SMART goal that your team wishes to achieve.)	
Plan:	
1. List the tasks needed to set up this test of change.	
2. Predict what will happen when the test is carried out.	

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3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome
Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			

<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

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Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			

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Notes:	

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				

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Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
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	HOSPITAL POLICY AND INFORMATION MANUAL		
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee	

Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				
--	--	--	--	--

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQUIP5 - 1.5.1 and 1.5.2 Infection Control
- EQUIP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

	HOSPITAL POLICY AND INFORMATION MANUAL	
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

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- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

**UNIVERSITY MEDICAL CENTER
PATIENT SAFETY PLAN 2019**

I. PURPOSE

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

This is achieved through:

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

II. SCOPE OF ACTIVITIES

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

- Patient safety
- Visitor safety
- Employee safety

All staff in University Medical Center of Southern Nevada is able to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, UMC has developed this Patient Safety Plan.

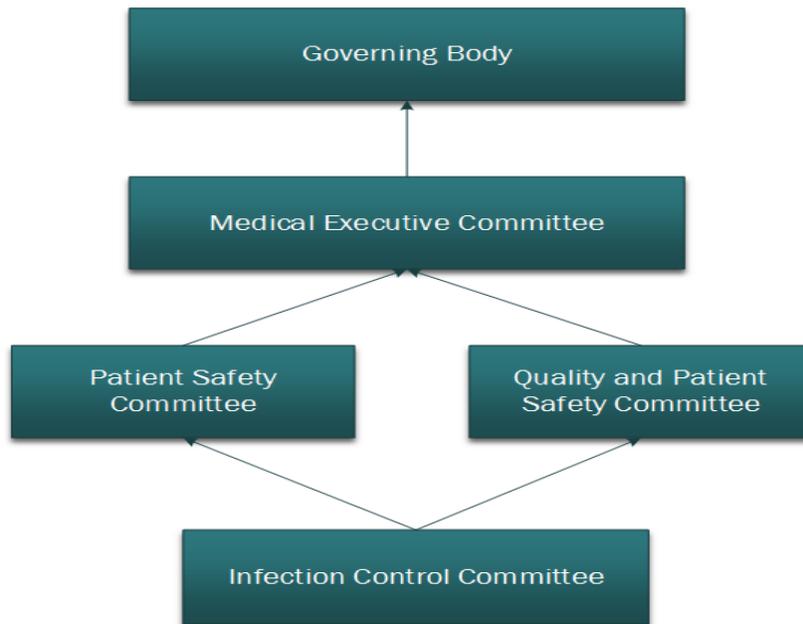
The plan focuses on the process and systems rather than the individual, and recognizes both internal and external customers, as well as facilitates the need for analyzing and improving processes. The core principles of this plan include:

- All staff are encouraged to contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.
- One Failure Mode Effect Analysis (FMEA) completed each year

III. ROLES AND RESPONSIBILITIES

In accordance with [NRS 439.875](#), UMC has established a Patient Safety Committee (PSC). The PSC is responsible to oversee UMC’s Patient Safety Program. As directed by the Board of Governors, the Patient Safety Committee will act as the hospital’s Grievance Committee.

Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Patient Safety Committee Responsibilities (NRS 439.875 and NRS 439.877):

- The Patient Safety Committee will meet at least monthly
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#)
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment, including the effectiveness of patient identification policy.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar quarter, report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the previous calendar quarter;
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
- The Patient Safety Committee shall be responsible for generating, evaluating and reviewing proactive risk assessments for the use of such documents and records in its proceedings. All risk assessments and associated documentation and records shall be subject to the applicable privileges under NRS 49.265 and NRS 439.875 provided that it is generated or produced during the Patient Safety Committee's review process.

Patient Safety Officer Responsibilities (NRS 439.870)

At UMC the Patient Safety Director is designated as the Patient Safety Officer. The Patient Safety Officer shall perform all duties and responsibilities required under Nevada law, including, without limitation:

- Serve on the Patient Safety Committee;
- Supervise the reporting of all sentinel events alleged to have occurred at UMC;
- Investigating the occurrence of Sentinel Events and implementing developed action plans;
- Report to the Patient Safety Committee

IV. COMPONENTS AND METHODS

Reporting of patient safety events:

All medical, nursing and support clinical staff are required to report any event, situation or circumstance that is significant or potentially significant to patient safety. These events will be reviewed and investigated as needed

This is accomplished by:

- Completing an event report in accordance with UMC policy
- Area manager/clinical supervisor review and completion of the manager's section of the event report
- Quality review by the Center for Quality and Patient Safety
- Review of significant/potentially significant events by the Patient Safety Officer
- Unit review of event types with action plan delivered at the Patient Safety Committee

Mandatory Reporting of Sentinel Events:

Pursuant to [NRS 439.835](#):

- A person who is employed by UMC shall, within 24 hours after becoming aware of a sentinel event, notify the Patient Safety Officer of the event.
- Within 13 days after receiving notification, the patient safety officer shall report the event to the Nevada Division of Public and Behavioral Health (DPBH).
- If the Patient Safety Officer personally discovers or becomes aware of a sentinel event, in the absence of notification by another employee, the patient safety officer shall report the event to DPBH within 14 days of discovery of the event must submit a report to The Health Division.

Disclosure of event to patient/family

Notification of patients who have been involved in a sentinel event will occur no later than 7 days after discovering or becoming aware of an event that occurred at the facility. Serious events

should be disclosed by the attending physician who has responsibility for overall care of the patient. If that is not possible, the Risk Manager or designee will disclose the event to the patient.

Pursuant to [NRS 439.837](#), UMC, upon reporting a sentinel event will conduct an investigation concerning the causes and/or contributing factors of the sentinel event and implement a plan to remedy the causes and/or contributing factors of the sentinel event.

Data Collection and Risk Assessment

Data should drive any quality and patient safety effort. UMC utilizes both internal and external sources for data collection.

Internal sources include but are not exclusive:

- Patient Safety Reporting system
- Patient and Family complaints
- Risk Management findings
- Morbidity/Mortality reviews
- Infection Control information
- Compliance findings
- Operative/procedural data
- Staff verbal reporting

External sources include but are not exclusive:

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

V. Patient Safety Checklists and Patient Safety Policies:

Patient Safety Checklists must follow protocols, are utilized to improve the health outcomes of patients at UMC and include, without limitation:

- Specific types of treatment, which include documentation that the treatment provided was properly ordered by the provider of healthcare.
- Ensuring that the patient's room and overall environment is sanitary.

- Discharge instructions that must include: proper instructions concerning prescription medications, aftercare instructions, and any individualized patient instructions.

Patient Safety Policies include, without limitation:

- Appropriate identification of patient prior to providing treatment requiring at least two personal patient identifiers
- Nationally recognized standard precaution protocols, including protocols relating to hand hygiene
- Compliance with the patient safety checklists and patient safety policies

Pursuant to [NRS 439.865](#), Policy # I-270, Patient Safety Checklists and Patient Safety Policies, is an extension of the Patient Safety Plan.

VI. Annual Patient Safety Plan and Evaluation:

The Patient Safety Officer reviews and updates the Patient Safety Plan annually. The Patient Safety Committee reviews the Patient Safety Plan annually and submits it to the Governing Board.

The Patient Safety Officer prepares a written annual evaluation of the patient safety program. The annual report assesses patient safety events and actions taken to improve patient safety. The report will be submitted through the performance improvement structure and to the Governing Board.

At a minimum, the written report includes the following:

- All system and process failures
- The number and types of sentinel events
- Whether patients and family were notified of events
- All actions taken to improve safety
- All actions taken in response to analyses related to the adequacy of staffing

VII. Approval of Patient Safety Plan

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

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

In compliance with [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) will be submitted to the Division of Public and Behavioral Health.

Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/voll/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Framework for conducting a Root Cause Analysis and Action Plan https://www.jointcommission.org/framework_for_conducting_a_root_cause_analysis_and_action_plan/
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>
- UMC Policy # I-270, Patient Safety Checklist and Policies <http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/2ad0126143283b0788257fef0059151e?OpenDocument>
- UMC Infection Prevention/Control Risk Assessment, Plan and Authority Statement <http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/b80ee5a6a929c63b88257f940064d794?OpenDocument>
- UMC Policy # I-69.1, Safety Intellivence (SI) Event Reporting [http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/5BDF4AAC322CB4BB8825812C00591607/\\$file/I-69_1_Safety_Intelligence.docx](http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/5BDF4AAC322CB4BB8825812C00591607/$file/I-69_1_Safety_Intelligence.docx)

Valley Hospital Medical Center

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

I. Overview

Valley Hospital endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. Valley Hospital operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that Valley Hospital remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by Valley Hospital to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at Valley Hospital. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with Valley Hospital policies. Valley Hospital employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.

- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.
- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

Valley Hospital’s mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

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

Valley Hospital recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

Valley Hospital has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer Responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

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

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and

Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventions.

C. Patient Safety

Valley hospital has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. Valley Hospital has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to Clear Sight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

Valley Hospital PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.

- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Valley Hospital is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate

organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their

responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. Risk Connect (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews

each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

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

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. UHSD Acute Care Division Patient Safety Priorities, Goals and Objectives for 2019

- **Surgical and Procedural Safety:**
 - **Wrong Site Surgery.**

- 5% reduction of 2019 Violence related harm events. Increase utilization of security assists with subsequent decrease in security emergency utilization which will further impact harm events.
 - Monitor through Midas EOC Dashboard, Loss Control Reports, Serious Incident debriefing and Health Stream training modules. Report quarterly with oversight by CPSC.
- **CLABSI/CAUTI Initiative**
 - **Goal:** CLABSI and CAUTI rates will be reduced by 10% each in 2019.
 - Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly with oversight by CPSC.
- **Executive Engagement in Safety/Safety Huddles**
 - **Goal:** 100% of essential safety huddle elements will be included in all hospital unit/department and Executive Safety Huddles.
 - Monitor through Observation/Mentoring Forms completed by Patient Safety Leads and Corporate resources. Report monthly with oversight by CPSC.
- **Safe Medication Use**
 - **Emergency Department Pyxis Optimization**
 - **Goal:**
 - Identify those limited emergency departments with ADCs that are not in profile mode.
 - Assess the barriers to converting those ADCs to profile mode and create a timeline for conversion by mid-Q1 2019.
 - Convert 100% of ADCs in the emergency departments to profile by Q2 2019.
 - Decrease the number of all-harm, medication events related to ADC overrides by 10% by December 2019.
 - Monitor through MIDAS reports, trigger tools, Cerner orders, and other intervention data. Report monthly with oversight by CPSC.
 - **Opioid Analgesic Event Reduction Initiative**
 - **Goal:** decrease the number of adverse drug events related to opioids by 10% by the end of 2019.
 - Monitor through Cerner, MIDAS, ICD-10 codes, and intervention data. Report monthly with oversight by CPSC.
 - **High Alert Medication Error Reduction**
 - **Goal:** 10% error reduction goal with warfarin and insulin medication administration errors.

- Monitor through MIDAS, Cerner, PSO reports, Pharmacist Interventions. Report monthly with oversight by CPSC.
 - **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls in the acute division by end of 2019.
 - Monitor through MIDAS event reporting. Report quarterly with oversight by CPSC.
 - The Risk Management program at Valley Hospital Medical Center would like to increase Midas Event reporting. There were a total of 5,146 Midas events entered in 2018, the goal is to increase this by 1,926 for 2019. (Numerator 1926/Denominator 5146 = 37.4% increase for 2019)
 - Falls Goals for 2019: Valley Hospital Medical Center would like to reduce/eliminate patient falls with serious harm to zero, this is congruent to our zero harm dashboard.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing

harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

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

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

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

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;

- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at

http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.



Quality, Patient Safety Plan

2019

This plan was created and revised by the Renown Health's Quality and Patient Safety Committee (QPSC). Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes. In addition, the plan is intended to encourage recognition, reporting, and acknowledgment of risks to patients, visitors, and employees as well as reduce medical/healthcare errors and/or preventable events. In addition this plan serves to direct the assessment of those services furnished directly by the organization or through contracted service, to identify opportunities to improve quality of those services and to implement appropriate corrective or improvement activities following the Plan, Do, Study, Act or PDSA model.

Quality and Patient Safety Plan

Contents

Commitment to Quality and Patient Safety	3
Mission, Vision, and Values	3
Scope and Purpose.....	3
Roles and Responsibilities.....	4
Components and Methods	6
Patient Safety Checklists and Patient Safety Policies	7
Approval of Quality and Patient Safety Plan	7

Commitment to Quality and Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, Renown Health's Quality and Patient Safety program promotes:

- Collaboration of leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Honest, open communication to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and values for each patient, family member, employee, and other healthcare providers.
- Responsibility for safety related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible patient outcomes.
- Incorporation of evidence-based safety practice guidelines to deliver high quality healthcare.
- Education of staff, physicians, new learners, patients and their families to promote patient safety and continuous quality improvement.

Scope and Purpose

This Quality and Patient Safety Plan applies across the entire Renown Health Acute Care Division.

All staff and physicians in Renown Health Acute Care Division are required to fully support and participate in this plan, and devote their expertise to the quality, patient safety, service and healthcare performance improvement process.

The purpose of this plan is to address safety, quality and service related concerns, challenges and to proactively identify opportunities to better serve patients and their families.

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

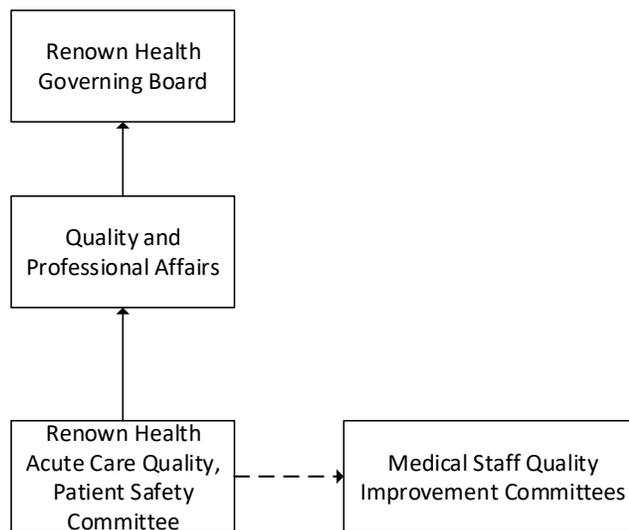
- Staff and physicians contributing their knowledge, vision, skill, and insight to improve the processes of quality, patient safety and service
- Promoting the concept that decisions are made based on data and facts
- A customer-focused approach including patients, families, and visitors

- System-based thinking
- Utilization of trained, expert staff and physicians.

Roles and Responsibilities

The Renown Health Acute Care Quality and Patient Safety Committee ensures that the Quality, Patient Safety Plan is promoted and executed successfully.

The Quality and Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), the Renown Health Acute Care Quality and Patient Safety Committee is comprised of:
 - The Renown Health Acute Care Infection Control Officer;
 - The Renown Health Acute Care Patient Safety Officer;
 - At least three providers of healthcare who treat patients, including at least one member of the medical, nursing and pharmaceutical staff;
 - One member of the executive or governing body;
 - A representative from Executive Leadership.

Quality and Patient Safety Committee Responsibilities (based in part on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy through event review and analysis when applicable.

- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
 - Number of sentinel events from previous calendar month
 - Number of hospital acquired infections that occurred in the organization
 - Corrective action plans for the sentinel events and infections.
- Review and evaluate the quality of measures carried out by the organization to improve the quality and safety of the care provided to patients.
- Review and evaluate the quality of measures carried out by the organization to prevent and control infections.
- Make recommendations to the executive or governing body of the organization to reduce the number and severity of sentinel events and infections.
- At least once each calendar quarter, report to the executive or governing body of the organization regarding:
 - (1) The number of sentinel events that occurred;
 - (2) The number and severity of infections that occurred; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
- A meeting agenda and minutes noting follow-up tasks will be kept.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the Renown Acute Care Quality and Patient Safety Committee.
- Supervise the reporting of all sentinel events alleged to have occurred, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred.
- Report to the QPSC directly or through his/her designee any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on in part on [NRS 439.873](#))

- Serve on the Renown Acute Care Quality and Patient Safety Committee.
- Monitor the occurrences of infections to determine the number and severity of infections.
- Report to the QPSC the number and severity of infections either directly or through his/her designee.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred.
- Carry out the provisions of the infection control program adopted pursuant in part to [NRS 439.865](#) and ensure compliance with the program.

Quality and Professional Affairs Committee of the Renown Health Board

- Provide vision and leadership that informs the safety processes, and develops and foster a safe learning and improving culture.
- Ensures the priorities of patient safety are aligned with the strategic priorities of the health system.

Components and Methods

The Renown Acute Care Quality and Patient Safety Committee uses data as a basis for recommendations for improvement.

Upon the identification of a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Root Cause Analysis

Renown Health Acute Care Division will use Root Cause Analysis (RCA) to determine the contributing factors and the underlying reasons for the deficiencies or failures involving sentinel events. Transformational Health Care principles and methods are incorporated into Renown’s RCA process.

An RCA is a process for identifying the root causes of process deviation or failure. It follows the principles of Just Culture by focusing on process reliability and failure rather than individual policy violation or failures.

Root Cause Analysis (RCA) Team Responsibilities

RCAs are conducted for all identified sentinel events and significant events/near misses involving complex process failure. Results of significant RCAs will be reported and monitored by the QPSC. RCA team responsibilities include:

- Conducting interviews in a fact-based, non-judgmental manner, analysis, investigation, and corrective action plan facilitation
- Coordination and participation in the RCA meetings and discussions
- Communicating in an honest and open manner regarding data and facts to with the team members and their supervisors/leaders
- Incorporating the principles of Just Culture in the RCA process.

Data Collection and Reporting

Data drives efforts to improve quality, safety and service. Renown Health uses Midas+ and other databases for tracking sentinel events, healthcare infections, patient grievances and other patient safety related data.

External data sources are also utilized for improvement efforts. These include but are not limited to:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention

- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Patient Safety Checklists and Patient Safety Policies

Another process used to improve quality, safety and service is the development of patient safety checklists and patient safety policies. Renown Acute Care anticipates that these checklists are utilized by:

- Providers of healthcare who provide treatment to patients at the organization;
- Other personnel who provide treatment or assistance to patients;
- Employees who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the organization; and
- Persons with whom the organization enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Renown Health Acute Care Quality and Patient Safety Committee reviews and approves annually patient safety checklists based on policy.

The Quality and Patient Safety Plan includes an infection control program that carries out the infection control policy. This program exists as individual and separate documents and consists of:

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

The Renown Health Infection Prevention Plan and Program is established and approved by the Renown Health Infection Control Committee. Regular reports and updates regarding the Infection Prevention Program are provided to the Patient Safety Committee.

Approval of the Quality and Patient Safety Plan

The Renown Health Quality and Patient Safety Plan is reviewed and updated annually and is approved by the Quality and Professional Affairs Committee of the Renown Health Board.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current Quality and Patient Safety plan must be submitted to the Division of Public and Behavioral Health.

WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL/RURAL HEALTH CLINIC

ADMINISTRATION POLICY & PROCEDURES

Department: Risk Management

Program/Manual: Patient Safety

Policy Subject: Patient Safety Plan

Section Number: P

Effective Date: 11-5-2007

Revision Date: 12-3-2013, 2-11-2015, 02-2019

I. INTRODUCTION

The Patient Safety Program supports and promotes the mission, vision and values of William Bee Ririe Hospital and Rural Health Clinic through organizational prioritization of patient, visitor and employee safety.

The patient safety program is implemented through the Enterprise Safety Committee and is supported by leadership's promotion of a safety culture that:

- Encourages recognition, reporting, and acknowledgment of risks to patient/visitor and employee safety and medical/healthcare errors
- Initiates/monitors actions to reduce risks/errors
- Internally report's findings and actions taken
- Promotes a blame-free culture facilitating the reporting and follow-up on safety concerns, errors and adverse events
- Educates staff and physicians to assure participation in the program

II. PURPOSE

The Patient Safety Program is designed to enhance patient care delivery and prevent adverse outcomes of care by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach focuses on actual and potential occurrences; ongoing proactive risk management; and integration of patient safety priorities in the development and revision of processes, functions and services.

III. MISSION, VISION AND VALUES

In support of the mission, vision and values of this organization the Patient Safety Program promotes;

- Collaboration among staff members, physicians and other providers to deliver comprehensive, integrated and quality health care.
- A focus on comprehensive, integrated quality service

- Open and honest communication to foster trust relationships among staff members, physicians, other providers and patients.

IV. OBJECTIVES

The objectives of the Patient Safety Program are to:

- Encourage organizational learning about adverse or potential adverse events
- Incorporate recognition of patient safety as an integral job responsibility
- Provide patient safety education
- Involve patients in decisions about health care and promote open communication
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate proactive measures
- Report internally any findings and actions taken to reduce risk
- Support sharing of knowledge to effect change
- Supplying support systems to health care workers who are involved in sentinel events.
- Have a sufficient number and mix of individuals to support safe, quality care, treatment, and services.

V. RESPONSIBILITIES/DUTIES

It is William Bee Ririe Hospital and Rural Health Clinic's responsibility to designate an officer or employee of the facility to serve as the patient safety officer of the medical facility.

The duties of the designated patient safety officer are:

- To serve as the patient safety officer of WBRH and RHC
- Serve on the Enterprise Safety Committee
- Supervise the reporting of all incident reports and/or sentinel events alleged entered in CCD Health Systems (Electronic QRR) to have occurred at the WBRH and RHC, including, without limitation, performing required pursuant to NRS 439.835
- Duties pursuant to 439.835 are
 - a) A person who is employed by WBRH and RHC shall, within 24 hours after becoming aware of a sentinel event that occurred at WBRH and RHC, notify the patient safety officer of the sentinel event.
 - b) The patient safety officer shall, within 13 days after receiving notification, report the date, the time and a brief description of the sentinel event to The Health Division and facility representative if that person is different from the patient safety officer.

- c) If the patient safety officer of WBRH and RHC personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at WBRH and RHC, the patient safety officer shall, within 14 days after discovering or becoming aware of the sentinel event report the date, time and brief description event to those listed in b) above.
- Take such action as he or she determine to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at WBRH and RHC
- Report to the Enterprise safety committee regarding any action taken in accordance to the above paragraph.

The Enterprise Safety Committee shall meet monthly.

The Patient Safety Plan and any changes thereafter shall be presented to the governing board of WBRH and RHC for approval.

The Patient Safety Plan must include, without limitation, the patient safety checklists and patient safety policies most recently adopted in regards to the patient safety plan.

After the WBRH and RHC's patient safety plan is approved, WBRH and RHC shall notify all providers of health care who provide treatment to patients at WBRH and RHC of the existence of the plan and of the requirements of the plan. WBRH and RHC shall require compliance with the patient safety plan.

The Enterprise safety Committee shall

- Receive reports from the Patient Safety Officer
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the facility
- Review and evaluate the quality of measures carried out by WBRH and RHC to improve the safety of patients who receive treatment at WBRH and RHC
- Make recommendations to the governing body of WBRH and RHC to reduce the number and severity of sentinel events that occur at WBRH and RHC.

The Enterprise Safety Committee provides a multidisciplinary forum for the collection and analysis of risk to patient safety and the dissemination of information on identified risk for the purpose of improving patient care. It shall review reports on occurrences including near misses to sentinel events. It shall identify those individuals or groups best situated to perform a root cause analysis and develop and implement an action plan for identified issues. It shall review, analyze and disseminate the information it receives, as appropriate, to the designated individuals and/or committees. It shall provide recommendations

concerning identified risks, approve plans for corrective actions and evaluate the implantation of corrective actions taken.

Membership may include representatives from administration, providers, clinical and support staff. Membership shall have at least 3 providers of healthcare who treat patients at WBRH and RHC, including without limitation, at least 1 member of the medical, 1 member of nursing and 1 pharmaceutical staff, member and 1 member of the governing body.

VI. SCOPE

The types of occurrences to be addressed include, but are not limited to, sentinel events, near misses, and actual events related to:

- a) Patient safety
- b) Adverse drug events (medication errors and adverse drug reactions)
- c) Health acquired infections
- d) Patient Falls
- e) Other patient incidents/unexpected clinical/medical events
- f) Unsafe conditions
- g) Visitor safety
 - Visitor incidents
- h) Employee safety
 - Blood/body fluid exposures
 - Occupational diseases
 - Communicable disease exposures
 - Musculoskeletal injuries
 - Immunization programs
 - Other employee incidents
- i) Environmental safety
 - Product recalls
 - Drug recalls
 - Product/equipment malfunction
 - Construction
 - Infection Control Risk Assessment
 - Water Quality
 - Air Quality
 - Disaster Planning
 - Security incidents
 - Workplace violence

Data from external sources, including but not limited to:

- Centers for Disease Control and Prevention (CDC)
- Joint Commission
- Institute for Healthcare Improvement (IHI)
- Institute for Safe Medication Practices (ISMP)
- Occupational Safety and Health Administration (OSHA)
- Nevada State Health Division
- Published literature

VII. DEFINITIONS

Serious Reportable (Sentinel) Event is defined by NRS 439.830 and means an event included in Appendix A of “Serious Reportable Events in Healthcare”. The seven (7) Serious Reportable Events along with their subsets are as follows:

Specifications of the Serious Reportable Events in Healthcare

1. Surgical or Invasive Procedure Events

- A. Surgery or other invasive procedure performed on the wrong site
- B. Surgery or other invasive procedure performed on the wrong patient
- C. Wrong surgical or other invasive procedure performed on a patient
- D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- E. Intraoperative or immediately post-operative/post-procedure death in an ASA Class 1 Patient

2. Product or Device Events

- A. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting
- B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
- C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

3. Patient Protection Events

- A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
- B. Patient Death or serious injury associated with patient elopement (disappearance).
- C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.

4. Care Management Events

- A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).

- B. Patient death or serious injury associated with unsafe administration of blood products
- C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
- D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.
- E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting.
- F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting.
- G. Artificial insemination with the wrong donor sperm or wrong egg.
- H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
- I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

5. Environmental Events

- A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting.
- B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances.
- C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting.
- D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

6. Radiologic Events

- A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

7. Potential Criminal Events

- A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- B. Abduction of a patient/resident of any age.
- C. Sexual abuse/assault on a patient or staff within or on the grounds of a healthcare setting.
- D. Death or serious injury of a patient or staff member from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

VIII. STRUCTURE

The authority for the Patient Safety Plan rests with the CEO, CNO, Quality Improvement Coordinator, Patient Safety Officer, and Chief of Medical Staff and has delegate the authority to implement and maintain activities described in this plan to the Enterprise safety committee.

IX. QUALITY REVIEW INFORMATION

To the extent possible, and in the manner consistent with the protection of confidentiality of quality assurance and patient safety data, pertinent information will be shared between the Quality Improvement Program and the Enterprise Safety Program.

In an attempt to protect quality review information from discovery, all quality review documents must be labeled as a Quality Review document. Documents should be in a formal format, handled by a limited number of individuals and secured in the Quality or Risk Managers Office accessible only to designated individuals. Nevada Revised Statute that protects quality documents is NRS49.265.

X. EDUCATION

Annual Staff and physician/provider education includes but is not limited to the following topics:

- Fire Drills
- Emergency and Disaster Drills
- Workplace violence
- Customer Service
- Creating, implementing, achieving, and maintaining a culture of Enterprise safety
- Risk management and error prevention
- Teamwork

XI. SAFETY IMPROVEMENT ACTIVITIES

Specify Measures Selected for an annual focus; (Examples are listed below)

- Patient satisfaction surveys
- Medical Record review; legible documentation, clear, complete, signed
- Complaints and resolution; to improve care and satisfaction (trends)
- Confidentiality; insure patient and employee information is secure
- Appointments/scheduling process; accessibility to physician
- Informed Consent Policy and Procedure
- Medication management and reconciliation i.e. current allergy information
- Telephone response time to callers
- Occurrence review

Give consideration to measures that facilitate safe practices; (Examples are listed below)

- Involve patients in their health care; consider literacy issues and cultural values, partner with patients in developing and planning their care plan.

- Use a team approach to safety; hold focused safety meetings
- Endorse open, effective communication; identify shared values and attitudes among all members. Interview and/or survey staff for attitudes, perceptions and communication barriers.
- Encourage error reporting to include near miss events. Institute a non-punitive reporting that is confidential and timely.
- Ensure employee and patient information or event reports shared with staff for educational purposes do not identify individuals.
- Facilitate communication skills learning (teamwork)
- Examine physical premises to identify and correct potential hazardous conditions.
- Orient physicians and new employees to risk management and patient safety concepts
- Conduct patient safety rounds
- Provide education and training on high risk processes.

XII. METHODOLOGY

A. Structure

- Proactive risk prevention strategies
- Identification of High Risk Areas
- General Incidences (Patient Injuries)
- Potential or actual adverse events (medication errors)

B. Method – Establish a process for;

- Identification, Selection, Prioritization
- Data Collection and Analyses
- Development of Actions
- Implementation
- Reporting
- Follow-up

C. Process Improvement – Establish teams/individual staff members to implement processes and to monitor for effectiveness.

Utilize applicable tools to facilitate improvement; for example

- PDCA: Plan, Do Check Act with focus on process improvement
- FMEA: Failure Mode Effect Analysis a systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk.
- RCA: Root Cause Analysis is a retrospective approach to error analysis that identifies what and how the event occurred and why it happened. The focus is on the process and systems not individuals.

XIII. PROGRAM EVALUATION

The Patient Safety Officer will submit monthly a report the Enterprise Safety Committee, Medical Staff and the Board of Directors

1. Definition of the scope of occurrence including sentinel events, near misses and serious occurrences that occurred at WBRH and RHC during the preceding month including;
 - Employee injuries
 - Potential lawsuits
 - Resolutions
 - Recommendations to the decrease of the number and severity of Sentinel Events

Yearly the Patient Safety Officer will submit to the Enterprise Safety Committee, Medical Staff and the Governing Board the following;

- a. Detail of activities that demonstrate the enterprise safety program has a proactive component by identifying the high-risk process selected.
- b. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis.
- c. A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles.
- d. The results of how input is solicited and participation from patients and families in improving patient safety is obtained.
- e. The results of the program that assesses and improves staff willingness to report errors.
- f. A description of the examples of ongoing education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

Yearly the Enterprise Safety Committee shall;

1. Monitor and document the effectiveness of the patient identification policy.
2. Review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
3. Revise a patient safety checklist and patient safety policy adopted as necessary to ensure that the checklist or policy reflects the most current standards in patient safety protocols.
4. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. This report must contain;

- Information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

XIV.NO CRIMAL PENALTY OR CIVIL LIABILITY

No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if the person, without malice;

- Reports sentinel event to a governmental entity with jurisdiction or another appropriate authority.
- Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event.
- Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority
- Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or
- Performs any other act authorized pursuant to NRS 439.800 to 439.890.

NRS439.860 ANY REPORT, DOCUMENT AND ANY OTHER INFORMATION COMPILED OR DISSEMINATED PURSUANT TO THE PROVISIONS OF NRS 439.800 TO 439.890, INCLUSIVE AND SECTION I OF AB 280 IS NOT ADMISSIBLE AS EVIDENCE IN ANY ADMINISTRATIVE OR LEGAL PROCEEDING CONDUCTED IN THE STATE OF NEVADA.



Willow Springs Center

A Residential Treatment Center for Children and Adolescents

Risk Management/Patient Safety Plan

2019

1. Overview

- A. Willow Springs has established a Risk Management/Patient Safety Plan that is supported by Senior Leadership to prevent, reduce, modify and eliminate conditions and practices that may create or cause loss. The safety and wellbeing of patients, personnel and the public is of the highest priority.

Mission and Vision

At Willow Springs, we are compassionate, committed and caring people, dedicated to inspire hope, as well as the ability to achieve and celebrate success through the power of relationships developed with children, families, and the communities we support. Willow Springs promotes clinical excellence, an environment of collaboration and trust while maintaining fiscal responsibility and integrity for patients, customers and the communities we serve.

2. Roles and Responsibilities

A. Risk Management/Patient Safety Officer

1. Behavioral Health Facilities designate Risk Managers to be responsible for risk identification and risk reduction.
2. The designated Risk Manager/Director is also the Patient Safety Officer
3. The Patient Safety Officer responsibilities based on [NRS 439.870](#) includes:
 1. Serve on the patient safety committee.
 2. Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
 3. Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility.
 4. Report to the patient safety committee regarding any action taken in accordance with paragraph iii.

B. Infection Control Officer

1. The Infection Control Officers responsibilities based on [NRS 439.873](#) includes:
 1. Shall serve on the patient safety committee.
 2. Shall monitor the occurrences of infections at the medical facility to determine the number and severity of infections.
 3. Shall report to the patient safety committee concerning the number and severity of infections at the medical facility.

4. Shall take such action as he or she determines is necessary to prevent and control infections alleged to have occurred at the medical facility.
 5. Shall carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.
2. Based on [NRS 439.865](#), the patient safety plan must also include an Infection Control Plan/Program that carries out the infection control policy. The policy must consist of:
 1. The patient safety checklists and patient safety policies most recently adopted pursuant to [NRS 439.877](#).
 2. An infection control program to prevent and control infections within the medical facility. To carry out the program, the medical facility shall adopt an infection control policy. The policy must consist of:
 1. The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization and the Society for Healthcare Epidemiology of America; and
 2. Facility-specific infection control developed under the supervision of a certified infection preventionist.
- C. Patient Safety Council (PSC)
1. The Patient Safety Council meets monthly and ensures
 2. According to [NRS 439.875](#), a medical facility shall establish a patient safety committee.
 1. A patient safety committee established pursuant to subsection 1 must be composed of:
 1. The infection control officer of the medical facility.
 2. The patient safety officer of the medical facility, if he or she is not designated as the infection control officer of the medical facility.
 3. At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.

4. One member of the executive or governing body of the medical facility.
2. A patient safety committee shall meet at least once each month.
 1. A patient safety committee shall meet at least once each month.
 2. The Administrator shall adopt regulations prescribing the composition and frequency of meetings of patient safety committees at medical facilities having fewer than 25 employees and contractors.
3. A patient safety committee shall:
 1. Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
 2. Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
 3. Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.
 4. Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections at the medical facility.
 5. Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at the medical facility.
 6. At least once each calendar quarter, report to the executive or governing body of the medical facility regarding:
 - a. The number of sentinel events that occurred at the medical facility during the preceding calendar quarter;
 - b. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
 - c. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
 7. Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
 8. The proceedings and records of a patient safety committee are subject to the same privilege and protection from

discovery as the proceedings and records described in [NRS 49.265](#).

4. Additional Patient Safety Committee Responsibilities, based on [NRS 439.877](#) includes Patient safety checklists and patient safety policies: Adoption by patient safety committee; required provisions; duties of patient safety committee.
 1. The patient safety committee established pursuant to [NRS 439.875](#) by a medical facility shall adopt patient safety checklists and patient safety policies for use by:
 - a. Providers of health care who provide treatment to patients at the medical facility;
 - b. Other personnel of the medical facility who provide treatment or assistance to patients;
 - c. Employees of the medical facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
 - d. Persons with whom the medical facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at the facility.
 2. The patient safety checklists adopted pursuant to subsection 1 must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:
 - a. Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
 - b. Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
 - c. A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - i. Proper instructions concerning prescription medications;
 - ii. Instructions concerning aftercare; and
 - iii. Any other instructions concerning his or her care upon discharge.
 - d. Any other checklists which may be appropriate to ensure the safety of patients at the medical facility.

3. The patient safety policies adopted pursuant to subsection 1 must include, without limitation:
 - a. A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of health care. The personal identifiers may include, without limitation, the name and date of birth of the patient.
 - b. A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of health care at the medical facility including, without limitation, protocols relating to hand hygiene.
 - c. A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, without limitation, active surveillance. Active surveillance may include, without limitation, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.
4. The patient safety committee shall:
 - a. Monitor and document the effectiveness of the patient identification policy adopted pursuant to paragraph (a) of subsection 3.
 - b. At least annually, review the patient safety checklists and patient safety policies adopted pursuant to this section and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
 - c. Revise a patient safety checklist and patient safety policy adopted pursuant to this section as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
 - d. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph (b).

D. Patient Safety Advisories/Alerts.

1. Advisories/Alerts are issued to facilities for the purpose of sharing pertinent information regarding a system or event that led to failure. Assessing these systems, can to lead to positive outcome so facilities can reduce the risk and avoid the same or similar outcome.
 2. Each facility should review the advisory and assure that processes are safe and appropriate.
- E. TERM Program.
1. WSC utilizes a risk management program identified as TERM, The Technical Elements Related to the Management of Patient Safety. The TERM document identifies expectations for our facility similar to a standard of care.
 2. Elements of TERM include:
 1. Administration of the RM and Patient Safety Program.
 2. Risk Identification.
 3. Patient Safety Orientation and Education.
 4. Risk Prevention Techniques.
 5. Contract Services.
 6. Risk Profiling.
 7. Patient Safety Council.
 8. Environment of Care.
 9. Claims and Litigation.
 10. Measuring the Effectiveness of the Patient Safety Program.
- F. MIDAS.
1. The entering of the facility's Healthcare Peer Review Reports (HPRs) for patients and non-patients into MIDAS+ as Risk Management Event Entries is the responsibility of the facility Risk Manager. They are entered on a regular basis and the Risk Manager utilizes the system to collect data through the various Risk Management Reports, which are written based on data from the event reports (HPRs) and MIDAS+.
- G. ENTERPRISE.
1. Enterprise is an electronic platform used to enter and track probable claims reports. A PCR is the facility's method of communicating the event and related findings/facts to Corporate Insurance staff.
- H. RCA – Root Cause Analysis.
1. The Root Cause Analysis and Action Plan tool has 24 analysis questions. The framework is intended to provide a template for answering the analysis questions and aid organizing the steps in a root cause analysis. All possibilities and questions should be fully considered in seeking "root cause(s)" and opportunities for risk reduction. Not all questions will apply in every case and there may be findings that emerge during the course of the analysis. For each finding we continue to ask "Why?" and drill down further to uncover why parts of the process occurred or didn't occur when they should have. Significant findings that are not identified as root causes themselves have "roots".
 2. According to [NRS 439.837](#), states that a Mandatory investigation of sentinel event by medical facility:

1. A medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.

I. Risk Management Goals and Objectives 2018:

1. Demonstrate compliance with the Centers for Disease Control and Prevention (CDC) and compliance with National Patient Safety Goal NPSG.07.01.10, demonstrating our compliance with hand hygiene guidelines.”
2. Educate new staff and facility adheres to the National Patient Safety Goals to improve patient safety.
3. Senior leadership conducts audit observation rounds which leads to maintaining patient safety and preventing harm to the patient.
4. Patient safety orientation and education for all new hires creates risk reducing practices.
5. Good Catch Program recognizes an event that could have been harmful to a patient, but was prevented. This creates and maintains an environment of non-punitive reporting

J. Approval of Patient Safety Plan.

1. According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the medical facility for approval in accordance with the requirements of this section.
 1. After a medical facility’s patient safety plan is approved, the medical facility shall notify all providers of health care who provide treatment to patients at the medical facility of the existence of the plan and of the requirements of the plan. A medical facility shall require compliance with its patient safety plan.
 2. The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

References:

<https://www.leg.state.nv.us/NRS/NRS-439.html>

<https://www.cdc.gov/handwashing/index.html>

<https://www.jointcommission.org/>

https://www.jointcommission.org/standards_information/npsgs.aspx

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 8/11

REVIEWED: 3/12, 2/13

POLICY: N-10 PATIENT SAFETY CHECKLIST

PROCEDURE:

1. A PATIENT SAFETY LIST WILL BE CONSTRUCTED BY THE MEMBERS OF THE SAFETY COMMITTEE. AND APPROVED BY MEMBERS OF THE MEDICAL EXECUTIVE COMMITTEE.
2. THE LIST WILL BE REVIEWED ANNUALLY AND REVISED BY THE SAFETY COMMITTEE WHEN DEEMED NECESSARY TO ENSURE THE CHECKLISTS REFLECT THE MOST CURRENT STANDARDS IN PATIENT SAFETY PROTOCOLS.
3. A PATIENT SAFETY LIST WILL BE COMPLETED FOR EACH PATIENT AND FOR EACH ADMISSION TO THE CENTER.
4. THE PATIENT SAFETY LIST WILL BE COMPLETED BY ALL EMPLOYEES INITIATING TREATMENT AT THE CENTER.
5. MONITORING AND EVALUATION OF THE PATIENT SAFETY LISTS AND PATIENT SAFETY POLICIES WILL BE DONE BY THE QAPI (QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT) COMMITTEE AND REPORTED TO THE SAFETY COMMITTEE, FACILITY OPERATIONS COMMITTEE, AND THE MEDICAL EXECUTIVE COMMITTEE.
6. THE SAFETY COMMITTEE WILL SUBMIT AN ANNUAL REPORT ON OR BEFORE JULY 1 OF EACH YEAR TO THE DIRECTOR OF THE LEGISLATIVE COUNSEL BUREAU FOR TRANSMITTAL TO THE LEGISLATIVE COMMITTEE ON HEALTH CARE. THE REPORT MUST INCLUDE INFORMATION REGARDING THE DEVELOPMENT, REVISION, AND USAGE OF PATIENT SAFETY CHECKLISTS AND PATIENT SAFETY POLICIES AND SUMMARY OF THE ANNUAL REVIEW CONDUCTED BY THE FACILITY.

SECTION: N SAFETY
11/11,

DATE: 11/97, 3/09,

1/13, 5/16

TITLE: N-20 CRASH CART CONTENTS

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TOP

- Zoll pacemaker/Defibrillator
- Portable Suction
- Crash Cart Manual
 - Crash Cart Check Sheet
 - Algorithms
 - Code Blue Record
 - Transfer Summary
 - Crash Cart Contents
 - Critical Care Drugs
 - Defibrillator Manual
 - Blood Draw
 - Malignant Hyperthermia references

BACK

- Back Board

LEFT SIDE

- E Tank Oxygen With Regulator
- Pacer Magnet

RIGHT SIDE

- IV Pole
- Ambu Bag With Mask

DRAWER 1

- 30 cc Syringes (2)
- 12 cc Syringes (4)
- 5 cc Syringes (5)
- 18g Needles
- Sharps Container
- Recording Paper (2)
- ECG Cable with Electrodes
- Electrode Gel
- Alcohol Preps
- AHA Emergency CV Care Handbook
- Pacer Cable with Pads
- Micro-Shield Disposable Barrier

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY
11/11,

DATE: 11/97, 3/09,
1/13, 5/16

TITLE: N-20 CRASH CART CONTENTS

DRAWER 2

- Sodium Bicarbonate 7.5% (2)
- Dextrose 50% (2)
- Calcium Chloride 10% (2)
- Atropine 1mg (6)
- Lidocaine 2% (2)
- Epinephrine 1mg (6)
- Vasopressin 20u (2)
- Adenosine 6mg (3)
- Amiodarone 450mg (2)
- Lasix 20mg (2)
- Narcan 0.4mg (2)
- Metoprolol 5mg (2)
- Dilantin 100mg (2)
- Valium 50mg (2)
- Benadryl 50mg (2)
- Digoxin 500mcg (2)

DRAWER 3

- Lactated Ringers 1000ml (2)
- 0.9% Sodium Chloride 250ml (4)
- Primary IV Set (2)
- Secondary IV Set (2)
- 3-way Stop Cocks (2)
- Disposable Pressure Infuser
- Dopamine 400mg (1)
- IV Start Kit
 - Razor
 - Tourniquet
 - Tape
 - Gauze 2x2
 - 19g Butterfly
 - 14g Jelco (2)
 - 16g Jelco (2)
 - 18g Jelco (2)
 - 20g Jelco (2)

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

PAGE 2 OF 4

SECTION: N SAFETY
3/09, 11/11,

DATE: 11/97,
1/13, 5/16

TITLE: N-20 CRASH CART CONTENTS

DRAWER 4

- McIntosh #3 & #4 Disposable Laryngoscopes
- Welch-Allyn Illuminator for Laryngoscopes
- 2% Xylocaine Jelly
- 10 fr. Intubating Stylet
- 14 fr. Intubating Stylet
- Cuffed (Endotracheal) tubes
 - 6.5 (3)
 - 7.0 (3)
 - 7.5 (3)
 - 8.0 (3)
- Suction tubing (2)
- 5 in 1 Adapters (2)
- Yankauer Suction Tip (2)
- 8 fr. Suction Catheter (1)
- 10 fr. Suction Catheter (2)
- 12 fr. Suction Catheter (2)
- 16 fr. Naso Gastric Tube
- Oral Pharyngeal airways
 - 80mm 100mm
 - 90mm 120mm
- Sterile Gloves size 6.5, 7, 7.5, and 8 (1 ea.)
- Oxygen Cannula (1)
- Oxygen Mask (1)
- Thoracotomy/Tracheotomy set
 - Shiley 6 Uncuffed Trach Tube
 - 22 fr. Foley
 - 15 Blades (2)
 - 2-0 Nylon Suture

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- Senn Retractors
- Knife handle
- Needle Holder
- Suture Scissor
- Kelly Clamp
- Betadine
- Gauze 4x4
- Lubricant

PAGE 3 OF 4

SECTION: N SAFETY
3/09, 11/11,

DATE: 11/97,
1/13, 5/16

TITLE: N-20 CRASH CART CONTENTS

DRAWER 5

- MALIGNANT HYPERTHERMIA
 - Dantrium Intravenous 20mg (18)
(18 vials are locked in narcotic cabinet)
 - Sterile Water for Reconstitution (100 cc X 15)
 - IV Administration Set (2)
 - IV Extension Sets (2)
 - 3-way Stop Cocks (2)
 - 60 cc Luer Lock Syringe (3)
 - 60 cc Cath Tip Syringe (2)
 - Foley Catheter, 16 Fr
 - Drain Bag
 - Zip Locks for Ice
 - Sterile Med Cup (2)
 - Blood Draw Tubes
 - Blue Top (2)
 - Green Top (2)
 - Red Top (2)
 - Purple Top (2)

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

MALIGNANT HYPERTHERMIA SUPPLIES - NOT IN CRASH CART

<u>ITEM</u>	<u>LOCATION</u>
Cubed Ice	Staff Lounge Freezer
Freeze Packs	Refreshment Refrigerator, Recovery Room
NACL Pour Bottles (1000 cc X 2)	Medication Refrigerator, Nursing Station
Lactated Ringer's I.V. (1000 cc X 2)	Medication Refrigerator, Nursing Station
Insulin Humulin R (1)	Medication Refrigerator, Nursing Station

PAGE 4 OF 4

SECTION: N SAFETY

DATE 11/97, 7/03, 9/14
REVIEWED: 3/12, 5/16

TITLE: N-30 CRASH CART AND DEFIBRILLATOR CHECK

POLICY: WILDCREEK SURGERY CENTER WILL MAINTAIN A CRASH CART AND DEFIBRILLATOR IN GOOD WORKING ORDER AT ALL TIMES. THE CRASH CART WILL BE FULLY STOCKED AND AVAILABLE FOR ALL CARDIO-PULMONARY EMERGENCIES IN THE FACILITY. ITEMS FROM THE CRASH CART WILL NOT BE USED IN ROUTINE PATIENT CARE IN ORDER TO ENSURE AVAILABILITY DURING AN EMERGENCY.

PROCEDURE:

- 1) THE CRASH CART WILL BE KEPT LOCKED DURING HOURS THE CENTER IS NOT IN OPERATION.
- 2) A CHECK LIST WILL BE KEPT ON TOP OF THE CRASH CART WHICH WILL BE SIGNED DAILY BY THE PERSON WHO CHECKS THE CART AND DEFIBRILLATOR.
- 3) THE PROCEDURE FOR CHECKING THE DEFIBRILLATOR IS AS FOLLOWS:

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- A) UNPLUG THE DEFIBRILLATOR AND PLUG THE DEFIBRILLATOR CABLE INTO THE TEST PORT.
 - B) TURN THE DIAL TO DEFIB.
 - C) ADJUST THE JOULES TO 30J.
 - D) PRESS THE CHARGE BUTTON. THE BUTTON WILL LIGHT UP AND BEEP INDICATING THE UNIT IS CHARGED.
 - E) WHEN CHARGED, PRESS THE SHOCK PUTTON
 - F) THE PANEL WILL DISPLAY "TEST OK".
 - G) PLUG THE UNIT BACK IN.
- 4) CHECK TO MAKE SURE THERE IS PAPER IN THE STRIP RECORDER.
 - 5) CHECK THE DEFIB PADS LOCATED ON THE TOP OF THE CART
 - 6) MAKE SURE THE OXYGEN TANK IS FULL AND SUCTION IS FUNCTIONING.
 - 7) ASSURE THAT CODE BLUE AND TRANSFERS RECORDS ARE AVAILABLE.

PAGE 1

OF 2

SECTION: N SAFETY

DATE 11/97, 7/03, 9/14
REVIEWED: 3/12, 5/16

TITLE: N-30 CRASH CART AND DEFIBRILLATOR CHECK

- 8) IF THE CART IS NOT LOCKED, THE ENTIRE CART MUST BE GONE THROUGH TO ASSURE THAT IS IT FULLY STOCKED, AND THAT ALL EQUIPMENT IS IN WORKING ORDER (I.E.; LARYNGOSCOPE BATTERIES AND LIGHT BULB).
- 9) CHECK THE DRUGS FOR EXPIRATION DATES.
- 10) SIGN THE CHECK LIST.
- 11) NOTHING IS TO BE PLACED IN OR ON THE CRASH CART THAT IS NOT ON THE APPROVED CONTENTS LIST.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

PAGE 2 OF 2

SECTION: N SAFETY
1/17

DATE: 11/97, 9/99, 7/03, 5/16,

REVIEWED: 3/12

TITLE: N-40 MALIGNANT HYPERTHERMIA

PROCEDURE:

1. MALIGNANT HYPERTHERMIA SUPPLIES ARE STORED IN THE BOTTOM DRAWER OF THE CRASH CART AND CHECKED DAILY AS PART OF THE CRASH CART PROCEDURE. MHAUS POSTERS WILL BE MAINTAINED AT THE CRASH CART AND IN BOTH SURGICAL SUITES.
2. SUPPLIES REQUIRING REFRIGERATION ARE STORED IN THE MEDICATION REFRIGERATOR AT THE NURSES STATION AND IN THE BREAK ROOM FREEZER
3. PATIENTS RECEIVING **MH** TRIGGERING AGENTS (SUCCINYLCHOLINE/INHALATION AGENTS) WILL BE OBSERVED FOR THE SIGNS AND SYMPTOMS OF **MH** BY ANESTHESIOLOGIST, OR AND PACU NURSING STAFF.
4. PATIENTS RECEIVING GENERAL ANESTHESIA WILL BE SCREENED FOR HISTORY OF **MH** BOTH SELF AND FAMILY. IN THE PRESENCE OF A POSITIVE HISTORY THE PROCEDURE WILL BE CANCELLED AND RESCHEDULE AT AN INPATIENT FACILITY.

SYMPTOMS TO OBSERVE FOR MALIGNANT HYPERTHERMIA

- **INTENSE MUSCLE RIGIDITY (USUALLY MASSETER MUSCLE FIRST)
CAN INVOLVE ENTIRE BODY.
- **RAPID INCREASE IN END TIDAL CO₂
- **RAPID DECREASE IN OXYGEN SATURATION

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

****SUDDEN UNEXPLAINED TACHYCARDIA.**
****TACHYPNEA**
****UNSTABLE BLOOD PRESSURE**
****ARRYTHMIAS**
****DARK BLOOD IN SURGERY FIELD, DESPITE ADEQUATE VENTILATION**
****CYANOTIC MOTTLING OF SKIN**
****PROFUSE SWEATING**
****FEVER, RAPID RISE OF 1 DEGREE/15 MIN, CAN RISE TO 108 DEGREES (42C) OR**

MORE

****CENTRAL VENOUS DESATURATION**
****CENTRAL VENOUS AND ARTERIAL HYPERCARBIA**
****METABOLIC ACIDOSIS**
****RESPIRATORY ACIDOSIS**
****HPERKALEMIA**
****MYOGLOBINEMIA**
****ELEVATED CPK**

**4. FOLLOWING THE SUSPECTED DIAGNOSIS OF MALIGNANT HYPERTHERMIA, THE ANES-
THESIOLOGIST WILL STOP ANESTHESIA. (MHAUS GUIDELINES WILL BE FOLLOWED)**

PAGE 1

OF 5

**SECTION: N SAFETY
1/17**

DATE: 11/97, 9/99, 7/03, 5/16,

REVIEWED: 3/12

TITLE: N-40 MALIGNANT HYPERTHERMIA

5. A 911 CALL WILL BE PLACED FOR AMBULANCE SERVICE RELAYING A PATIENT PICK-UP WITH POSSIBLE **MH.**

6. THE ANESTHESIA MACHINE WILL BE PURGED WITH HIGH FLOW O2 AND NEW HOSES ATTACHED PER REQUEST OF ANESTHESIOLOGIST.

7. THE CIRCULATING NURSE WILL INITIATE A CODE BLUE DESIGNATING THE AREA AND BRING CRASH CART/HYPERTHERMIA CART TO ARE.

8. PACU WILL RESPOND WITH INSULIN , MANNITOL AND ICE.

9. THE PROPER LAB WILL BE NOTIFIED FOR STAT PICK-UP OF BLOOD AND URINE

10. THE ANESTHESIOLOGIST WILL HYPERVENTILATE THE PATIENT WITH 100% O2 AT A FLOW OF 8-10 LITERS/MIN

11. DANTROLENE SODIUM (DANTRIUM) WILL BE ADMINISTERED I.V. ASAP

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

AT A STARTING DOSE OF 2MG/KG TO A TOTAL OF 10MG/KG VIA RAPID INFUSION. NEARBY SURGERY CENTERS WILL BE ALERTED TO BE ON STAND-BY FOR ADDITIONAL DANTRIUM.

12. COOLING OF THE PATIENT WILL BE INITIATED:
- A. IV ICED NORMAL SALINE ADMINISTERED 15CC/KG/15 MIN X 3 DOSES
 - B. SURFACE COOLING WITH ICE PACKS (AND CRUSHED ICE IN ZIPLOCK BAGS)
 - C. LAVAGE OF STOMACH, BLADDER, RECTUM, PERITONEAL AND THORACIC CAVITIES AS APPLICABLE WITH ICED SALINE TO A TOTAL OF 3-6 LITERS
13. THE CIRCULATING NURSE WILL NOTIFY THE O.R. NURSE MANAGER TO SECURE ARRANGEMENTS FOR:
- A. STAT PICK-UP OF LAB WORK: ABG,S, ELECTROLYTES, CPK, LDH, MYOGLOBIN, MG, COAG STUDIES, URINE FROM INITIAL FOLEY INSERTION FOR
 - B. TRANSFER ARRANGEMENTS TO HOSPITAL OF THE PHYSICIAN'S CHOICE.
 - C. AMBULANCE ARRANGEMENTS

PAGE 2
OF 5

SECTION: N SAFETY
1/17

DATE: 11/97, 9/99, 7/03, 5/16,

REVIEWED: 3/12

TITLE: **N-40 MALIGNANT HYPERTHERMIA**

14. THE O.R. SCRUB TECHNICIAN WILL ASSIST THE SURGEON TO SECURE THE SURGERY SITE TO PREVENT CONTAMINATION AND ATTAIN HEMOSTASIS

15. THE CIRCULATING NURSE AND/OR ASSIGNED STAFF MEMBER WILL ASSIST THE ANESTHESIOLOGIST IN INSERTING AND SECURING MONITORING LINES: ARTERIAL, NG, FOLEY, RECTAL TUBES ETC.

16. THE SURGEON, ANESTHESIOLOGIST, AND CIRCULATING NURSE WILL ACCOMPANY THE PATIENT TO THE ADMITTING HOSPITAL, SPACE PERMITTING.

17. DOCUMENTATION WILL BE MADE ON:

- A. THE PATIENT CHART
- B. THE CODE RECORD

18. THE O.R. NURSE MANAGER WILL:

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- A. ARRANGE TRANSPORTATION OF TRANSPORT TEAM BACK TO CENTER
- B. NOTIFY THE ADMINISTRATOR AND MEDICAL DIRECTOR
- C. COMMUNICATE THE INCIDENT TO THE QI/RM COMMITTEE AND OBTAIN APPROPRIATE PEER REVIEW

MALIGNANT HYPERTHERMIA PROTOCOL

- 1) ANESTHESIOLOGIST/ CIRCULATOR:
 - A) STOPS ANESTHESIA / SURGERY
 - B) CALL A CODE BLUE AND DESIGNATE AREA
 - C) CHANGING OF CIRCUITS AND BARALYME AT ANESTHESIOLOGISTS REQUESTS

PAGE 3

OF 5

SECTION: N SAFETY
1/17

DATE: 11/97, 9/99, 7/03, 5/16,

REVIEWED: 3/12

TITLE: N-40 MALIGNANT HYPERTHERMIA

- 2) AVAILABLE STAFF:
 - A) BRINGS CRASH CART/M.H. CART TO DESIGNATED AREA
 - B) PACU STAFF WILL BRING INSULIN TO AREA
 - C) ICED SALINE AND FREEZE PACKS WILL BE OBTAINED FROM EMPLOYEE LOUNGE FREEZER AND BROUGHT TO AREA.
 - D) CRUSHED ICE WILL BE OBTAINED FROM FREEZER IN EMPLOYEE LOUNGE AND BROUGHT TO AREA.
- 3) R.N./CIRCULATOR WILL ASSIGN STAFF TO:
 - A) MIX DANTRIUM
 - B) INSERT FOLEY CATHETER-----REMEMBERING TO SAVE FIRST RETURN FOR STAT LAB
 - C) RECORD EVENTS ON CODE BLUE RECORD
 - D) NOTIFY APPROPRIATE LAB (APL) FOR STAT PICKUPS
 - E) ASSIST ANESTHESIOLOGIST WITH DRAWING SPECIMENS, STARTING LINES AND/OR LAVAGE.

MALIGNANT HYPERTHERMIA CART SUPPLIES

- Dantrium Intravenous 20mg (36)
- Sterile Water for Reconstitution (1000 cc X 3)
- IV Administration Set (2)

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- Oxygen Mask, Adult, Disposable with 7 Foot Tubing
- Laboratory Kit (2) (Tiger Top Tube (2), Blue Top Tube, Arterial Blood Sample Syringe (2), Sterile Urine Cup, Laboratory Order Form)
- Malignant Hyperthermia Emergency Protocol
- Foley Catheter, 16Fr
- Foley Catheter, 22Fr
- Zip Lock Bags for Cubed Ice
- 2 oz Catheter Tip Syringe (2)
- Urinary Drainage Bag
- Nasogastric Tube, 16 Fr
- Sterile Lubricant Packets (6)

PAGE 4 OF 5

SECTION: N SAFETY
1/17

DATE: 11/97, 9/99, 7/03, 5/16,

REVIEWED: 3/12

TITLE: N-40 MALIGNANT HYPERTHERMIA

MALIGNANT HYPERTHERMIA SUPPLIES - NOT IN CRASH CART

<u>ITEM</u>	<u>LOCATION</u>
Cubed Ice	Staff Lounge Freezer
Freeze Packs (10)	Staff lounge freezer
NACL Pour Bottles Room (1000 cc X 2)	Medication Refrigerator, Recovery
Lactated Ringer's I.V. Room (1000 cc X 2)	Medication Refrigerator, Recovery
Insulin (Humulin R) ROOM	Medication Refrigerator, Recovery

STAT LAB WORK

*****BLACK / RED TUBES X 2: CPK, LDH, ELECTROLYTES (NA, K, CL, CA, MG)

*****BLUE TUBE: PT (COAGULATION)

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

*****YELLOW URINE: URINE FOR MYOGLOBIN

PAGE 5

OF5

SECTION: N SAFETY
3/10

DATE: 11/97, 7/03,

8/12, 11/13,

5/16

TITLE: N-50 MANAGEMENT OF A LATEX ALLERGY

POLICY: WILDCREEK SURGERY CENTER SHALL MAINTAIN OR HAVE PROMPT ACCESS TO NECESSARY EQUIPMENT, SUPPLIES, DRUGS, AND PERSONNEL TO EFFICIENTLY MEET THE DEMANDS OF A PERSON WHO HAS A LATEX ALLERGY.

PROCEDURE:

1. SCREENING:

UPON ADMISSION, PATIENTS WILL BE ASKED ABOUT ANY LATEX ALLERGIES. IN PATIENTS WITH SUCH ALLERGIES, IT NEEDS TO BE DETERMINED TO WHAT EXTENT THE ALLERGY INVOLVES.

2. RECOGNITION:

A. TYPE I HYPERSENSITIVITY (PROTEIN ALLERGY). THIS IS DEFINED AS AN ALLERGY TO SOME OF THE PROTEINS FOUND IN NATURAL RUBBER LATEX. TYPE I ALLERGIES MAY PRODUCE URTICARIA, SWOLLEN EYELIDS OR LIPS, RESPIRATORY DISTRESS, RHINITIS, AND CAN RESULT IN SYSTEMIC ANAPHYLAXIS. INDIVIDUALS WITH A TYPE I HYPERSENSITIVITY TO NATURAL RUBBER

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

LATEX SHOULD ONLY USE A SYNTHETIC GLOVE OR ALTERNATIVELY A VINYL GLOVE BENEATH LATEX.

B. TYPE IV HYPERSENSITIVITY (CHEMICAL ALLERGY). TYPE IV HYPERSENSITIVITY IS A CHEMICAL ALLERGY TO THE ACCELERATORS, STABILIZERS, PRESERVATIVES, OR OTHER CHEMICALS. THIS REACTION PRESENTS ITSELF AS DRY THICKENED SKIN WITH POSSIBLE BUMPS OR SORES, BUT DOES NOT DEVELOP INTO SYSTEMIC REACTIONS.

3. MANAGEMENT:

A. IN THE CASE THAT A LATEX ALLERGY BECOMES EVIDENT DURING A PROCEDURE, ADAPT THE ENVIRONMENT ACCORDING TO THE SEVERITY OF THE ALLERGY. THE FOLLOWING EQUIPMENT MAY NEED TO BE TAKEN INTO CONSIDERATION:

1 OF 4

PAGE

SECTION: N SAFETY
3/10
5/16

DATE: 11/97, 7/03,
8/12, 11/13,

TITLE: N-50 MANAGEMENT OF A LATEX ALLERGY

- GLOVES-WEAR VINYL GLOVES. WEARING VINYL GLOVES MAY BE ALL THAT IS REQUIRED FOR SOME ALLERGIC REACTIONS.
- MONITORS AND OTHER EQUIPMENT-SOME EQUIPMENT, SUCH AS BLOOD PRESSURE CUFFS AND TUBING AND STETHOSCOPE TUBING MAY CONTAIN LATEX.

B. THE PATIENT SHOULD BE GIVEN AN ALLERGY BAND STATING HIS/HER ALLERGY TO LATEX.

C. A MASTER LIST OF COMMONLY USED LATEX ITEMS WILL BE AVAILABLE TO PERSONNEL RESPONSIBLE FOR THE CARE OF THE LATEX ALLERGY PATIENT.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

PATIENT
FOR
D. ALL O.R. PERSONNEL CARING FOR THE LATEX ALLERGIC
PERI-OPERATIVELY WILL ADHERE TO THE GUIDELINES SPECIFIC
THE CARE OF THESE PATIENTS.

NURSING CARE FOR THE PATIENT WITH LATEX ALLERGY NURSING CHECK-OFF LIST

PRE-OP:

1. IDENTIFY IF PATIENT HAS A LATEX ALLERGY.
2. ASSURE THAT CHART IS CLEARLY DOCUMENTED STATING THAT A
LATEX ALLERGY IS PRESENT.

PAGE 2 OF 4

SECTION: N SAFETY
3/10
5/16

DATE: 11/97, 7/03,
8/12, 11/13,

TITLE: N-50 MANAGEMENT OF A LATEX ALLERGY

3. LATEX FREE GLOVES SHOULD BE WORN FOR ANY PATIENT
CARE/CONTACT.
4. ASSURE THAT ALL MEMBERS OF THE HEALTH CARE TEAM ARE AWARE
OF THE LATEX ALLERGY (O.R. CHARGE NURSE, ANESTHESIOLOGISTS, ETC.)
5. REFER TO THE LIST OF LATEX FREE ITEMS AND HAVE ALTERNATIVES
AVAILABLE. POSTED IN PRE-OP MEDICATION CABINET AND SUBSTERLE
SUTURE CABINET.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

INTRA-OP:

- 1. LATEX WILL BE LISTED ON PATIENT ALLERGY BRACELET AND DOCUMENTED IN RED ON ALL CHART RECORDS.**
- 2. HANG SIGN ON O.R. DOOR TO IDENTIFY LATEX ALLERGY.**
- 3. USE NON LATEX ITEMS TO SUBSTITUTE FOR LATEX PRODUCTS**
- 4. WRAP WEBRIL AROUND ARM AND OR LEG TO PREVENT BLOOD PRESSURE CUFF TUBING AND OR TOURNIQUET CUFF TUBING FROM COMING IN CONTACT WITH THE PATIENTS SKIN.**
- 5. ASSESS THE STERILE FIELD WITH THE SCRUB NURSE TO ASSURE A LATEX FREE SETUP**
- 7. COMMUNICATE WITH THE PACU NURSE PRIOR TO PATIENT'S ARRIVAL REGARDING THE PATIENTS LATEX ALLERGY.**

3 OF 4

PAGE

SECTION: N SAFETY
3/10

DATE: 11/97, 7/03,

5/16

8/12, 11/13,

TITLE: N-50 MANAGEMENT OF A LATEX ALLERGY

LATEX ITEMS:

- 1. BLADDER AND TUBING IN BLOOD PRESSURE CUFF**
- 2. STETHASCOPIES**
- 3. EXAM GLOVES**
- 4. STERILE SURGICAL GLOVES**

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

PAGE 4 OF 4

SECTION: N SAFETY

DATE: 11/97, 7/03, 2/13, 3/12
REVIEWED: 5/16

TITLE: **N-55 CODE BLUE ANNOUNCEMENT**

POLICY:

WILDCREEK SURGERY CENTER WILL ENSURE THAT THE RESPONSE TO A CARDIO-PULMONARY ARREST IS CONDUCTED IN A TIMELY MANNER AND WITH ADEQUATE PERSONNEL TO PERFORM RESUSCITATION.

PROCEDURE:

1. THE PERSON IDENTIFYING THAT A CONDITION OF EMERGENCY EXISTS WILL CALL A CODE BLUE, OR IF ATTENDING TO THE PERSON IN DISTRESS, WILL DIRECT ANOTHER EMPLOYEE TO CALL THE CODE BLUE. IMMEDIATELY FOLLOWING THE CODE BLUE ANNOUNCEMENT THE EMPLOYEE WILL CALL 911 AND REQUEST AMBULANCE SUPPORT AND TRANSFER.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

2. A CODE BLUE IS CALLED BY; PICKING THE RECIEVER ON ANY PHONE, DIALING 8888 AND ANNOUNCING THE CODE BLUE ALONG WITH THE LOCATION OF CODE BLUE PATIENT.
 3. THE CODE BLUE TEAM AND ALL AVAILABLE EMPLOYEES AND PHYSICIANS WILL RESPOND.
 4. THE CODE BLUE TEAM WILL CONSIST OF:
 - AN ANESTHESIOLOGIST AND/OR SURGEON.
 - A RN TO DIRECT TRAFFIC.
 - A PACU NURSE TO BRING AND MANAGE THE CRASH CART.
 - 2 CERTIFIED ACLS PERSONNEL.
 - A RN DOING DOCUMENTATION.
 5. PERSONNEL ON THE CODE BLUE TEAM:
 - THE ANESTHESIOLOGIST IN ATTENDANCE WILL RESPOND TO THE CODE BLUE
 - PACU NURSE MANAGER OR NURSE MANAGER AND/OR QA NURSE WILL RESPOND IF DEEMED NECESSARY.
 - ALL AVAILABLE PACU NURSES WILL RESPOND BRINGING THE CRASH CART WITH DEFIBRILLATOR.
 - ALL AVAILABLE EMPLOYEES AND PHYSICIANS WILL RESPOND AND REMAIN UNTIL IT IS EVIDENT THAT ADEQUATE COVERAGE IS AVAILABLE.
 - ALL INVOLVED PERSONNEL ARE TO RETURN OR REMAIN WITH OTHER PATIENTS OR FAMILIES
 - A WRITTEN EVALUATION WILL BE COMPLETED FOLLOWING THE CODE BLUE
- AND
- PRESENTED TO THE QAPI AND SAFETY MEETINGS.

SECTION: N SAFETY
7/03, 9/09, 5/16

DATE: 11/97,

REVIEWED: 3/12

TITLE: N-60 DEVICE TRACKING

POLICY: WILDCREEK SURGERY CENTER WILL SUPPORT AND COMPLY WITH THE PROVISIONS SET FORTH BY THE SAFE MEDICAL DEVICES ACT IN REGARDS TO TRACING SPECIFIED IMPLANTABLE DEVICES. IMPLEMENTED ON AUGUST 29, 1993, THIS ACT DIRECTS ITS

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

ATTENTION TO THE ABILITY TO CONTACT RECIPIENTS OF THE IMPLANTABLE DEVICE IN THE EVENT OF A RECALL.

PROCEDURE:

1. ALL PERMANENTLY IMPLANTABLE DEVICES WILL BE TRACKED. THESE INCLUDE THE FOLLOWING:

- BREAST PROSTHESIS
- EAR PROSTHESIS (DOES NOT INCLUDE MYRINGOTOMY TUBES)
- FINGER IMPLANTS
- HOMOGRAFTS (CORNEA, TYMPANIC MEMBRANE, FASCIA, ETC.)
- HUNTER RODS
- INFUSION PUMPS
- INTRAOCULAR LENS
- AMNIO GRAFTS
- MESH (MARLEX, PROLENE, SURGIPRO, GORETEX, ETC.)
- MOLTENO IMPLANTS
- PLATES
- SPINAL CORD STIMULATORS (PERMANENT)
- TOE IMPLANTS

2. WHEN AN IMPLANT, OTHER THAN AN INTRAOCULAR LENS, IS USED, THE CIRCULATOR WILL PUT IMPLANT INFORMATION (CATALOG #, TYPE AND SERIAL OR LOT NUMBER), AND A REGISTRATION FORM, IF AVAILABLE, IN THE IMPLANT BOOK. IMPLANT INFORMATION IS MARKED RIGHT OR LEFT FOR MAMMARY PROSTHESIS. THE CIRCULATING NURSE WILL SEND THE APPROPRIATE REGISTRATION FORMS TO THE MANUFACTURER.

3. WHEN AN INTRAOCULAR LENS IS USED, THE CIRCULATOR WILL USE THE IOL LOG BOOK FOR PATIENT AND IMPLANT INFORMATION. AN IMPLANT STICKER IS ALSO PLACED ON THE INTRA-OPERATIVE RECORD WHICH IS A PERMANENT PART OF THE PATIENT RECORD. THE IMPLANT BOX CONTAINING THE

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

IMPLANT STICKERS AND PATIENT INFORMATION CARD
ARE GIVEN TO THE
DISCHARGE PERSONNEL WHO COMPLETES THE PATIENT
INFORMATION CARD
AND GIVES TO THE PATIENT UPON DISCHARGE.

SECTION: N SAFETY

DATE: 11/97, 8/98, 7/03

REVIEWED: 3/12, 5/16

TITLE: N-70 PROTECTION AGAINST OCCUPATIONAL EXPOSURE TO INFECTIOUS DISEASES

POLICY: WILDCREEK SURGERY CENTER WILL PROVIDE A SAFE AND HEALTHFUL ENVIRONMENT THROUGHOUT ITS FACILITIES. THE CENTER WILL PROVIDE EXPLICIT GUIDELINES FOR THE PROTECTION OF ALL EMPLOYEES WHO MAY BECOME EXPOSED OR HAVE CONTACT WITH HUMAN BLOOD OR BODY FLUIDS.
THE CENTER WILL COMPLY WITH ALL RULES, LAWS, REGULATIONS, AND GUIDE-LINES PERTAINING TO THE SAFETY AND HEALTH OF ITS EMPLOYEES.

PROCEDURE: RESPONSIBILITIES OF ALL EMPLOYEES AND MEMBERS OF THE MANAGEMENT STAFF ARE AS FOLLOWS:

DEPARTMENT MANAGERS' RESPONSIBILITIES:

- 1) EACH DEPARTMENT MANAGER WILL EVALUATE AND CLASSIFY EVERY POSITION UNDER THEIR JURISDICTION IN ACCORDANCE WITH THE EXPOSURE CATEGORIES THAT FOLLOW.
- 2) THE APPROPRIATE EXPOSURE CATEGORY WILL THEN BE INCORPORATED INTO THE INDIVIDUAL POSITION DESCRIPTION.
- 3) ONCE EACH POSITION HAS BEEN PROPERLY CLASSIFIED, THE INDIVIDUALS OCCUPYING THAT POSITION WILL BE ADVISED IN WRITING OF THE EXPOSURE CATEGORY WHICH BEST FITS THE POSITION, AND THE PROTECTIVE MEASURES TO BE IMPLEMENTED FOR THAT CATEGORY.
- 4) EACH MANAGER WILL DEVELOP AND MAKE AVAILABLE WRITTE STANDARD OPERATION PROCEDURES FOR ALL EXPOSURE CATEGORY I AND II TASKS. THESE STANDARD OPERATING PROCEDURES SHOULD BE READILY AVAILABLE FOR ALL EMPLOYEES WHO PERFORM CATEGORY I AND II TASKS. WORK PRACTICES SHOULD BE DEVELOPED ON THE ASSUMPTION THAT ALL BODY FLUIDS AND TISSUES ARE INFECTIOUS.
- 5) PROCEDURES WILL BE DEVELOPED OR REVISED FOR THE CONTROL OF SPILLS AND PROPER HANDLING AND DISPOSAL METHODS FOR

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

CONTAMINATED CLOTHING AND EQUIPMENT.

PAGE 1 OF 4

SECTION: N SAFETY

DATE: 11/97, 8/98, 7/03

REVIEWED: 3/12, 5/16

TITLE: N-70 PROTECTION AGAINST OCCUPATIONAL EXPOSURE TO INFECTIOUS DISEASES

- 6) EACH MANAGER WILL DEVELOP AND ESTABLISH AN INITIAL AND PERIODIC TRAINING FOR ALL EMPLOYEES WHO PERFORM EXPOSURE CATEGORY I AND II TASKS. NO WORKERS SHOULD ENGAGE IN ANY EXPOSURE I AND II TASKS BEFORE RECEIVING TRAINING PERTAINING TO THE WORK PRACTICES AND PROTECTIVE EQUIPMENT REQUIRED FOR THOSE TASKS
- 7) A POLICY OR SURVEILLANCE WILL BE ESTABLISHED BY THE MANAGER OR APPROPRIATE SUPERVISOR TO ENSURE THAT REQUIRED WORK PRACTICES ARE OBSERVED, AND THAT PROTECTIVE CLOTHING AND EQUIPMENT ARE PROPERLY PROVIDED AND USED.
- 8) ALL KNOWN OR SUSPECTED PENETRATING CONTACTS WILL BE INVESTIGATED TO ESTABLISH THE CONDITIONS SURROUNDING THE EXPOSURE AND TO IMPROVE TRAINING AND WORK PRACTICES OR PROTECTIVE EQUIPMENT TO PREVEN A REOCCURRENCE.
- 9) EACH MANAGER WILL ENSURE THAT ANY NEW POSITION DESCRIPTION INCLUDE THE APPROPRIATE EXPOSURE CATEGORY.

EXPOSURE CATEGORIES:

CATEGORY I: TASKS THAT INVOLVE EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES. ALL PROCEDURES OR OTHER JOB RELATED TASKS THAT INVOLVE AN INHERENT POTENTIAL FOR MUCOUS MEMBRANE OR SKIN CONTACT WITH BLOOD, BODY FLUIDS, OR TISSUES, OR POTENTIAL FOR SPILLS OR SPLASHES OF THE SAME, ARE CATEGORY I.

CATEGORY I PROTECTIVE MEASURES:

- 1) FOR SKIN EXPOSURE: GLOVES, GOWNS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- 2) FOR MUCOUS MEMBRANE EXPOSURE: EYE SHIELDS, MASKS.
- 3) FOR CLOTHING EXPOSURE: APRONS OR GOWNS.

OF 4

PAGE 2

SECTION: N SAFETY

DATE: 11/97, 8/98, 7/03
REVIEWED: 3/12, 5/16

TITLE: N-70 PROTECTION AGAINST OCCUPATIONAL EXPOSURE TO INFECTIOUS DISEASES

CATEGORY II: TASKS THAT INVOLVE NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES, BUT EMPLOYMENT MAY REQUIRE UNPLANNED CATEGORY I TASKS. THE NORMAL WORK ROUTINE INVOLVES NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES, BUT THE EXPOSURE OR POTENTIAL EXPOSURE MAY BE REQUIRED AS A CONDITION OF EMPLOYMENT.

CATEGORY II PROTECTIVE MEASURES:

THERE WILL BE READY ACCESS TO APPROPRIATE PROTECTIVE CLOTHING AND EQUIPMENT, (I.E. GLOVES, MASKS, GOWNS, AND EYE SHIELDS) BUT THE CATEGORY II WORKERS NEED NOT WEAR THESE AT ALL TIMES. THEY MUST, HOWEVER, BE PREPARED TO PUT ON PROTECTIVE EQUIPMENT AT ANY TIME AND ON SHORT NOTICE.

CATEGORY III: TASKS THAT INVOLVE NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES. THE TASKS PERFORMED IN CATEGORY I ARE NOT A CONDITION OF EMPLOYMENT. THE NORMAL WORK ROUTINE INVOLVES NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES. EMPLOYEES WHO PERFORM CATEGORY III TASKS ARE NOT CALLED UPON AS PART OF THEIR JOB TO PERFORM OR ASSIST IN CATEGORY I OR II TASKS. TASKS THAT INVOLVE CASUAL CONTACT (SHAKING HANDS, USING PUBLIC OR SHARED BATHROOMS, OR HANDLING OF PENS AND PENCILS) ARE CATEGORY III TASKS.

PERSONNEL EXPOSURE CATEGORIES:

CATEGORY I:
CIRCULATING NURSES

CATEGORY II:
LAUNDRY PERSONNEL

CATEGORY III:
ADMITTING CLERK

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SCRUB NURSES
SCRUB TECHNICIANS
INSTRUMENT TECHS
ANESTHESIA AIDES
PRE-OP NURSES
PACU NURSES

HOUSEKEEPING

RECEPTIONIST
BILLING CLERK
INSURANCE CLERK
MEDICAL RECORDS CLERK
SCHEDULING CLERK

PAGE 3

OF 4

SECTION: N SAFETY

DATE: 11/97, 8/98, 7/03
REVIEWED: 3/12, 5/16

TITLE: N-70 PROTECTION AGAINST OCCUPATIONAL EXPOSURE TO INFECTIOUS DISEASES

STANDARD OPERATING PROCEDURES:

CATEGORY I:

ALL PERSONNEL PERFORMING CATEGORY I TASKS WILL WEAR THE APPROPRIATE PROTECTIVE CLOTHING AND EQUIPMENT. THIS INCLUDES MASKS, GOWNS, GLOVES, AND EYE SHIELDS. PROTECTIVE GARB WILL BE WORN DURING ALL CONTACTS WITH HUMAN BLOOD, BODY FLUIDS, OR TISSUES. THIS

INCLUDES SKIN PREPARATION OF THE OPERATIVE SITE, ASSISTING WITH OR STANDING NEAR THE OPERATIVE SITE, AND CLEANING OF THE OPERATING ROOM AND EQUIPMENT AFTER THE CASE IS FINISHED. PROTECTIVE GARB WILL ALSO BE USED DURING TRANSFER OF THE PATIENT TO AND FROM THE OPERATING TABLE, AND HOOK-UP OF MONITORING EQUIPMENT AND ANESTHETIC INDUCTION.

CATEGORY II:

PROTECTIVE CLOTHING AND EQUIPMENT READILY AVAILABLE FOR USE. THIS INCLUDES MASKS, GLOVES, GOWNS, AND EYE SHIELDS. THIS GARB NEED NOT BE WORN AT ALL TIMES, BUT MUST BE DONNED WHEN PERFORMING TASKS THAT INVOLVE ANY CONTACT WITH OR POTENTIAL SPLASHING OF BLOOD, BODY FLUIDS, OR TISSUES. THIS INCLUDES ORAL, NASAL AND ET TUBE

SUCTIONING, STARTING/DISCONNECTING IV'S, CHANGING/REINFORCING IV'S, CHANGING/REINFORCING DRESSINGS, HANDLING OF SOILED LINENS, FINGER-STICK BLOOD SAMPLING, AND CLEANING SOILED/CONTAMINATED EQUIPMENT. CASUAL CONDUCT SUCH AS

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

ASSISTING THE PATIENT TO DRESS DOES NOT REQUIRE PROTECTIVE CLOTHING AND EQUIPMENT.

CATEGORY III:
FOR
II EXPOSURE,
PERFORM THE TASK.

NO SPECIAL PROTECTIVE CLOTHING OR EQUIPMENT IS REQUIRED
CATEGORY III TASKS. IF A TASK REQUIRES CATEGORY I OR
THE APPROPRIATE PERSONNEL WILL BE CALLED TO

PAGE 4

OF 4

SECTION: N SAFETY
7/03, 9/04

DATE: 11/97,

REVIEWED: 3/12, 5/16

TITLE: N-80 PATIENT OR VISITOR INCIDENT OR INJURY

POLICY: wildcreek surgery center will outline procedures for reporting unusual incidents that occur in or around the Center and/or any of its facilities or properties regardless of the degree of seriousness at the time of the occurrence as follows:

PROCEDURES:

- 1) The Center shall document all unusual Occurrences.
- 2) Employees and staff will be cautioned against committing to the Center's liability through their actions or statements in the presence of patients, visitors, or others at any time.
- 3) All variance involving patients will be reported to the Risk Management Nurse.
- 4) No employee shall be terminated for an unintentional nonmalicious occurrence if it is reported provided that said employee is not violating any policies that are currently in effect. However, failure to report an incident will be grounds for disciplinary action.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

5) In the case of personal injury to a visitor on the Center's premises, the Department Manager shall be immediately notified, and a variance report filled out.

6) In the case of theft, disturbance, or unauthorized solicitation, the Department Manager must be notified, and the Manager will investigate and complete a Variance Report.

7) When Center owned items or materials are involved in an occurrence, the Variance Report is to be completed by the staff member working in the area where the event occurred.

page 1 of

4

SECTION: N SAFETY
7/03, 9/04

DATE: 11/97,

REVIEWED: 3/12, 5/16

TITLE: N-80 PATIENT OR VISITOR INCIDENT OR INJURY

8) Equipment malfunction or equipment user error during treatment or diagnosis of a patient that did or could have adversely effected the patient or personnel involved MUST be reported. Variances that require reporting in this category involve potential harm to patients, actual harm to patients, or failure to provide needed services on a timely basis to patients due to equipment malfunction or Equipment user error.

9) A Variance Report must be completed for the unscheduled termination of any service vital to the continued safe operation of the facility, or to the health and safety of the staff and patients. This includes, but is not limited to: termination of the telephone, electricity, gas, water, heat, air CONDITION-

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

ing services or supplies.

10) Any employee involved in, observing, or DISCOVERING AN unusual occurrence is responsible for initiating a Variance Report. The

Department Manager will assist in the completion of the report if necessary.

11) The Manager of the Department involved in the occurrence has the responsibility of forwarding all Variance Reports to the Risk ManAGER within 24 hours.

12) The Risk ManaGER will review all Variance Reports. All non-patient occurrences will be reviewed by the Administrator. Follow-up RESPONSES, WHEN NECESSARY, WILL be kept in the Risk Management files.

13) Patient related Variance Reports will be maintained in the Risk Management files.

14) The Risk ManaGER will follow up with patients, visitors, employees, or medical staff as the situation mandates.

15) The Risk ManagER will follow up on all miscellaneous employees, or visitor safety Variances. This may involve working with each department to determine the specific cause of the variance reported.

16) In all cases of medication loss, the Director of Pharmacy Services will be notified.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY
7/03, 9/04

DATE: 11/97,

REVIEWED: 3/12/ 5/16

TITLE: N-80 PATIENT OR VISITOR INCIDENT OR INJURY

SURGICAL CENTER OWNED ITEMS OR MATERIALS:

1. Notification: When completing a Variance Report of this nature the following information should be provided.

- a. Description of item(s) or material(s) involved
 1. Manufacturer, or manufacturer's serial #
 2. Any other related identification

B. The person completing the Variance Report should also state the facts that let them to believe it was a possible Center-owned item(s) or material(s) involved in the occurrence.

C. The item(s) involved are to be immediately removed from service, and the Department Manager is to tag the item(s) as soon as possible. The Manager of the department involved is to contact the Risk Management coordinator to report such occurrences. The Risk Manager will then contact the Center's Administrator for further direction or INVOLVEMENT Of the Center's attorney if necessary. Further investigation into the matter may be advised or required.

d. if a medical device has been determined to be a contributing factor in the harming of a patient, a report will be filed in compliance with the "safe medical device act". (refer to policy **n-160**)

2. Tagging:

A. As soon as the item(s) or material(s) involved are taken out of service, the item(s) are to be tagged. The tag should specify the following:

1. Name and I.D. number of patient involved;
2. Date of occurrence;

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

3. A listing of all persons who have handled the item(s) after the OCCURRENCE and the dates of handling.

3. Outside Experts:

The Administrator will, at the discretion of the center's Attorney, decide if the item(s) or material(s) should be inspected by outside experts. The Administrator will arrange for the outside expert to check the item(s) or material(s) in question.

page

3 of 4

SECTION: N SAFETY
7/03, 9/04

DATE: 11/97,

REVIEWED: 3/12, 5/16

TITLE: N-80 PATIENT OR VISITOR INCIDENT OR INJURY

If the item(s) need to be transported to the outside expert, the Administrator will be responsible for transportation. The report of this investigation will be forwarded to the Administrator and the Center's Attorney.

4. Preventive Maintenance Records and Policies and Procedures Regarding

The Use Of Items and Materials:

The Administrator or Department Manager should secure all Preventive Maintenance and Service Records as well as service contracts on all items/materials. A copy of this information will be kept on file and any policies and procedures regarding the use of these items/materials should also be kept on file in the Department Manager's office.

5. Items or Materials Not Owned By The Center:

A. When any item(s) or material(s) that are no owned by the Center are involved in an

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

occurrence, approval needs to be obtained from the owner of the item(s)/ material(s) before they can be sent out or tested.

B. If there is a disagreement between owner of the item(s)/material(s) as to the testing or procedure to be followed, the Administrator will be contacted.

6. Foreign Bodies:

When a foreign body is removed from a patient and it Appears that it may have been involved in an injury to the patient, the specimen should be sent to Pathology according to standard procedures. A Variance Report should be written on which it is specified that the specimen was sent to Pathology and the date it was sent. If necessary, the Nursing Department Manager will then contact Pathology so that the specimen can be retained.

foreign bodies which are material to criminal investigation will be directly turned over to the appropriate law enforcement agent.

page

4 of 4

SECTION: n safety
11/97, 7/03

DATE:

5/16

reviewed: 3/12,

TITLE: n-90 ON-THE-JOB INJURIES OF EMPLOYEES

POLICY: WILDCREEK SURGERY CENTER will assure appropriate TREATMENT and compensation, THROUGH THE SIIS PROGRAM, for employees who incur job-related injury or illness, and will

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

establish the time when the employee may safely resume their job.

PROCEDURE:

1. ACCIDENT REPORT: EMPLOYEE'S RESPONSIBILITIES:
 - a. Report every accident incurred to the supervisor in charge, Regardless of how minor in nature.
 - b. Complete a Variance Report and a State Industrial Insurance Report.
 - c. If treatment is needed or desired, employee should inform their supervisor, and will see the Medical Director or house physician.
 - d. Report back to the supervisor following treatment, and inform the Department Manager of any days' work lost or to be lost.

2. DEPARTMENT MANAGER'S RESPONSIBILITIES:
 - a. Upon receiving report of an accident by an employee, give the Employee a Variance Report and instruct the employee to complete the report, unless immediate treatment is indicated.
 - b. The employee should be sent to the Medical Director or house P hysician for treatment. If immediate treatment is necessary, the employee should complete the Variance Report upon their return from treatment. If the employee is advised not to return to work, the Manager should complete the Variance Report to the greatest extent possible. The form must be signed by the employee, as well as the SIIS form.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

page 1 of

3

SECTION: n safety
11/97, 7/03

DATE:

reviewed: 3/12,

5/16

TITLE: n-90 ON-THE-JOB INJURIES OF EMPLOYEES

Following examination by the Medical Director or house Physician, if a limited work status is indicated, determine if such Work is available for the employee. if limited work is not available, check with other Department Managers for such work and obtain their approval before offering the limited work to the employee.

d. Review the forms and reports from care given to ensure Appropriate medical follow-up care is provided to the employee.

E. Coordinate with other Department Managers the return to work status of injured or ill employees.

f. Review all payments, fees, and charges from licensed Practitioners and other medical providers, and assure that there are medical reports. Sign and submit receipts to the Accounts Payable department, as well as any claims paid by the SIIS.

3. MEDICAL DIRECTOR'S RESPONSIBILITIES:

a. Examine and treat or refer for treatment all on-the-job injuries incurred by employees. If the Medical Director is not available, then the designated house physician will assume these responsibilities.

b. Consult with the Department Manager to determine "full work" or "limited work" status.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

c. If the employee's condition requires additional treatment, the _____ Medical Director will provide the employee with a list of physician specialists best qualified to treat the condition. The employee can _____ select one of these physicians or any other physician of their choice _____ for the additional treatment.

d. Contact or arrange for an appointment with the selected _____ physician and forward all pertinent reports to that physician via _____ the employee or other means, if indicated.

4. RISK MANAGEMENT COORDINATOR'S RESPONSIBILITIES:

a. Immediately evaluate the Variance Report to determine if and to _____ what extent a safety investigation is needed.

b. Complete the appropriate item for corrective action indicated. _____ Consult with the appropriate Department Manager to determine _____ estimated date corrective action will be completed, if immediate corrective action is not possible.

c. Obtain the number of previous accidents incurred by this _____ employee. If the number of previous accidents seems to be excessive, _____ consider medical evaluation such as an eye examination, hearing _____ test, or a complete physical exam, or educational counseling to _____ eliminate future accidents.

PAGE 2 of

3

SECTION: n safety
11/97, 7/03

DATE:

5/16

reviewed: 3/12,

TITLE: n-90 ON-THE-JOB INJURIES OF EMPLOYEES

d. If this type of accident seems to be prevalent throughout the _____ Center, refer this to the QA Committee for review and recommend _____ action.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

E. If immediate corrective action is not possible, follow-up corrective action at a later specified date.

f. Record all injuries/illnesses according to guidelines of OSHA, reportable on a master log.

5. CHANGE OF PHYSICIAN:

A. If the employee is not satisfied with the first physician chosen, they may make an alternative choice of physicians if the choice is made within 90 days after the injury. Any further change is subject to the approval of the insurer.

6. COMPLICATIONS AND TRANSPORTATION:

A. An employee who has reported to the Medical Director or house physician for treatment of an injury or illness which is job related, and finds their condition TO worsen or become complicated outside of working hours, is authorized to report to an Emergency Room or Urgent Care Center for further consultation and/or treatment.

B. If ambulance transportation is necessary, the employee is to notify their Department Manager if possible and obtain approval for such transportation.

7. RETURN TO WORK:

A. Before returning to work, an employee who has been absent from their duties due to an occupational disability or injury for five

(5) or more working days, must have a medical release from the

Medical Director, house physician, or personal physician.

B. Employees returning to work following an occupational injury/ illness must report to their Department Manager prior to Performing any duties with WILDCREEK SURGERY CENTER under any circumstances.

C. Copies of physician or any other related medical releases provided by an employee must be placed in the Workman's Compensation File.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

D. Employees granted unpaid leave time are responsible for _____ arranging to continue their group life benefits and their health or _____ dependent coverage if the unpaid leave of absence period exceeds _____ thirty (30) days.

3 of 3

SECTION: N SAFETY
10/10, 8/13

page

DATE:

REVIEWED: 7/14, 5/16

TITLE: N-100 EMERGENCY MANAGEMENT PLAN-DISASTER PREPAREDNESS

POLICY:

THE SURGERY CENTER ACCEPTS THE RESPONSIBILITY TO ESTABLISH A PLAN TO ENSURE THE PROMPT AND EFFECTIVE ACTIONS NECESSARY TO PROTECT PATIENTS, VISITORS, AND STAFF IN THE EVENT OF AN INTERNAL AND/OR EXTERNAL DISASTER. THIS PROTECTION WILL BE PROVIDED BY EMPLOYEES, THE ADT MOTION DETECTOR ALARM, AND LOCAL OFFICIALS. ALL EMPLOYEES WILL ABIDE BY THE FOLLOWING PROCEDURES TO ENSURE THE SAFETY OF ALL PERSONS AT THE CENTER.

PROCEDURES:

THE FACILITY WILL NOT BE A DIRECT PARTICIPANT IN THE COMMUNITY DISASTER PLAN. THE FACILITY WILL NOT BE OPEN 24 HOURS PER DAY AND 7 DAYS PER WEEK. THE FACILITY WILL PROVIDE ASSISTANCE, AS REQUESTED, IN THE FORM OF HEALTHCARE SUPPLIES, EQUIPMENT, AND/OR PERSONNEL TO OTHER HEALTHCARE FACILITIES IN THE COMMUNITY IN THE EVENT OF AN EXTERNAL DISASTER.

AN **INTERNAL DISASTER** IS A SITUATION THAT OCCURS WITHIN THE SURGERY CENTER INTERFERING WITH THE NORMAL OPERATIONS, PRODUCING ACTUAL OR POTENTIAL CASUALTIES AND REQUIRING EMERGENCY ACTION FROM WITHIN OR FROM OUTSIDE TO MINIMIZE DAMAGE.

AN **EXTERNAL DISASTER** IS DEFINED AS ANY INCIDENT OCCURRING IN THE GEOGRAPHICAL AREA SURROUNDING THE SURGERY CENTER, PRODUCING ACTUAL OR POTENTIAL MULTIPLE CASUALTIES, AND/OR CAUSING DAMAGE OR DANGER TO THE CENTER ITSELF.

NOTIFICATION:

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

THE FACILITY PROVIDES ELECTIVE OUTPATIENT SURGERY ON A PART TIME BASIS. THE FACILITY WILL BE CLOSED IN THE EVENT OF AN IMPENDING DISASTER THAT HAS THE POTENTIAL TO HARM THE CENTER AND ITS OCCUPANTS. SHOULD THE CENTER BE IN OPERATION DURING A DISASTER CURRENT SURGERIES WOULD CONCLUDE, PATIENTS STABILIZED AND EVACUATE PER POLICY. THE FACILITY WILL REMAIN CLOSED UNTIL SUCH A TIME THAT NORMAL OPERATIONS CAN BE SAFELY RESUMED.

THE FACILITY WILL CONTINUALLY MONITOR RADIO AND TELEVISION BROADCASTS IN ADDITION TO NOTIFICATIONS FROM THE COUNTY AND/OR CITY DEPARTMENT OF EMERGENCY MANAGEMENT.

THE ADMINISTRATOR AND/OR DESIGNEE WILL CONTACT ALL KEY PERSONNEL BY PHONE.

WHEN IT IS DETERMINED THAT THE FACILITY WILL REMAIN OPERATIONAL, ALL KEY STAFF WILL BE NOTIFIED BY PHONE AND INSTRUCTED TO ASSEMBLE, VIA THE SAFEST DIRECT ROUTE.

EMERGENCY POWER:

THE EMERGENCY POWER SUPPLY FOR THE FACILITY IS PROVIDED BY AN EMERGENCY GENERATOR THAT WILL PROVIDE CONSISTENT ELECTRICAL POWER AND LIGHT TO ALL NECESSARY EQUIPMENT IN THE EVENT OF ELECTRICAL FAILURE.

EMERGENCY CONTACT INFORMATION:

THE FIRST LINE OF AUTHORITY WILL BE THE ADMINISTRATOR. IF THE ADMINISTRATOR IS UNABLE TO PERFORM THIS DUTY, THE DESIGNEE IS THE NURSE MANAGER. TO ENSURE CONTINUOUS LEADERSHIP AND AUTHORITY DURING AN EMERGENCY, THE FOLLOWING IS THE CHAIN OF COMMAND: ADMINISTRATOR, NURSE MANAGER, STAFF REGISTERED NURSES, SURGICAL TECHNICIANS AND BUSINESS STAFF.

ADMINISTRATOR AND/OR NURSE MANAGER:

IN THE EVENT OF A DISASTER THE ADMINISTRATOR OR DESIGNEE WILL CONTACT THE LOCAL AUTHORITIES AND AWAIT FURTHER INSTRUCTION.

NURSE MANAGER:

THE NURSE MANAGER IS RESPONSIBLE TO CONDUCT A YEARLY DISASTER PREPAREDNESS DRILL IN ACCORDANCE WITH THE **STATE OF NEVADA** AND **CMS** REQUIREMENTS. IN ACCORDANCE WITH **AAAHC** THE CENTER WILL CONDUCT AT LEAST ONE (1) DRILL EACH CALENDAR QUARTER AND ONE OF THOSE DRILLS MUST BE A CPR TECHNIQUE DRILL A WRITTEN EVALUATION WILL BE COMPLETED FOR EACH DRILL AND FORWARDED TO THE APPROPRIATE COMMITTEES AT WHICH TIME THE ORGANIZATION WILL PROMPTLY IMPLEMENT ANY MODIFICATIONS TO THE PLAN.

EMPLOYEES RESPONSIBILITIES:

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TEAMWORK IS ESSENTIAL WHEN A DISASTER OCCURS; THEREFORE EACH EMPLOYEE NEEDS TO BE FAMILIAR WITH THE TASKS AND RESPONSIBILITIES THAT WILL BE IMPLEMENTED IN THE EVENT OF A DISASTER. DURING THEIR INITIAL ORIENTATION TO THE FACILITY, EACH NEW EMPLOYEE WILL BE INTRODUCED TO THE PLAN, AND SUBSEQUENTLY REQUIRED TO UNDERSTAND THEIR DUTIES IN THE EVENT OF A DISASTER.

PATIENT TRANSPORT/ TRANSFER LOG

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

BOMB THREAT:

A BOMB THREAT AGAINST THE CENTER MAY BE RECEIVED BY TELEPHONE, MAIL, OR MESSAGE AT ANY TIME AND IN ANY LOCATION. ALL THREATS SHOULD BE CONSIDERED AS A REAL AND SERIOUS DANGER TO THE LIVES OF PATIENTS, STAFF, AND VISITORS, AND DESTRUCTION OF THE CENTER'S FACILITIES.

NOTIFICATION OF A BOMB THREAT:

- 1) **BY TELEPHONE:** THE PERSON RECEIVING THE CALL SHOULD ATTEMPT TO OBTAIN AS MUCH INFORMATION AS POSSIBLE:
 - EXACT LOCATION OF THE BOMB.
 - TIME SET FOR DETONATION.
 - DESCRIPTION OF EXPLOSIVE CONTAINERS.
 - TYPE OF EXPLOSIVE.
 - REASON FOR CALL OR THREAT.

DURING THE COURSE OF THE CONVERSATION, THE PERSON RECEIVING THE CALL SHOULD WRITE DOWN ALL AVAILABLE INFORMATION. IN ADDITION, THE RECEIVER SHOULD NOTE AS MUCH OF THE FOLLOWING INFORMATION AS POSSIBLE:

- DATE AND TIME CALLED.
- EXACT LANGUAGE USED.
- SEX OF CALLER.
- ESTIMATED AGE OF CALLER.
- PECULIAR OR IDENTIFIABLE ACCENT OF CALLER.
- APPARENT KNOWLEDGE OF THE CENTER BY DESCRIPTION OF LOCATIONS WITHIN THE CENTER.

OF 5

PAGE 1

TITLE: N-110 INTERNAL DISASTER: BOMB THREATS, CODE STRONG

- 2) **BY MAIL OR MESSAGE:** ONCE THE PERSON RECEIVING THE BOMB THREAT RECOGNIZES IT AS SUCH, THIS PERSON WILL NOTIFY THEIR DEPARTMENT MANAGER AND

ADMINISTRATOR

IMMEDIATELY. DO NOT LEAVE THE LOCATION OF THE RECEIVED THREAT; THE DEPARTMENT MANAGER AND ADMINISTRATOR WILL COME TO THE SITE. NO OTHER PERSONS WILL HANDLE THE PIECE OF MAIL OR MESSAGE, INCLUDING ANY ENVELOPE OR CONTAINER IT MAY HAVE COME

IN.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SEARCH PROCEDURE:

- TO:
- THREAT
- 1) THE ADMINISTRATOR WILL NOTIFY THE LOCAL POLICE OF THE RECEIVED BY DIALING 911.
 - 2) THE ADMINISTRATOR WILL MAKE THE DECISION OF WHETHER
 - SEARCH THE BUILDING
 - EVACUATE THE PREMISES
 - 3) IF A SEARCH IS DECIDED ON, THE DEPARTMENT MANAGER WILL INITIATE THE SEARCH AND ASSIGN MEMBERS TO ASSIST.
 - 4) ALL EMPLOYEES SHOULD ACT CALMLY AND QUIETLY DURING THE SEARCH. DO NOT ANNOUNCE OR OTHERWISE ALARM PATIENTS AND VISITORS.
 - 5) ALL EMPLOYEES SHOULD MAINTAIN A FAMILIARITY WITH ALL EQUIPMENT, MATERIALS, AND SUPPLIES NORMALLY UTILIZED AT THE CENTER. THIS ALLOWS FOR EASY DETERMINATION OF ITEMS THAT DO NOT BELONG IN THE CENTER WHICH MAY POSSIBLY BE AN EXPLOSIVE DEVICE.
 - 6) DURING THE SEARCH, EMPLOYEES SHOULD DIRECT CLOSE ATTENTION TO: STRANGE OR UNFAMILIAR PACKAGES OR SMALL ARTICLES; DOORS TO CABINETS OR CLOSETS WHICH ARE NOT IN THEIR NORMAL POSITION, SUCH AS PARTIALLY OPENED WHEN THEY ARE NORMALLY CLOSED; OR A PIECE OF FURNITURE OR EQUIPMENT NOT IN ITS NORMAL LOCATION.
 - 7) UPON DISCOVERY OF ANY OF THE ABOVE SITUATIONS, WILDCREEK SURGERY CENTER PERSONNEL MUST NOT ATTEMPT TO MOVE OR DISTURB ANY ITEM OR ABNORMAL CONDITION FOUND. THEY SHOULD IMMEDIATELY NOTIFY THE ADMINISTRATOR OF THE SITUATION SO THAT QUALIFIED INDIVIDUALS CAN INVESTIGATE THE MATTER.

PAGE
2 OF 5

TITLE: N-110 INTERNAL DISASTER: BOMB THREATS, CODE STRONG

- 8) IF AN EVACUATION OF THE BUILDING IS DECIDED ON, ALL CENTER EMPLOYEES SHOULD FOLLOW THE SAME PLAN AS FOR A FIRE EVACUATION.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

RESPONSIBILITIES OF DEPARTMENT MANAGERS:

- A
- 1) POLICIES OF THEIR RESPECTIVE AREAS AT ALL TIMES. THE IMPORTANCE OF GOOD HOUSEKEEPING AND ORDERLY ARRANGEMENT OF MATERIALS AND SUPPLIES CANNOT BE OVEREMPHASIZED. THIS WILL FACILITATE THOROUGH AND SPEEDY SEARCH OF THE ENTIRE CENTER.
 - 2) ENSURING THAT ALL PERSONNEL WITHIN THEIR RESPECTIVE AREAS ARE FAMILIAR WITH THIS PLAN AND THE IMPORTANCE OF REMAINING CALM WHEN A THREAT IS RECEIVED. THIS IS PARTICULARLY IMPORTANT IN PATIENT CARE AREAS.
 - 3) UPON NOTIFICATION OF A THREAT, INSTRUCT EACH EMPLOYEE TO SEARCH THEIR IMMEDIATE AREA FOR STRANGE OR UNFAMILIAR OBJECTS OR CONTAINERS.
 - 4) EMPLOYEES SHOULD BE INSTRUCTED NOT TO HANDLE OR MOVE ANY SUSPICIOUS OBJECTS OR SITUATIONS.
 - 5) PROPER SECURITY OF THEIR AREAS, PARTICULARLY EXTERIOR ACCESSES TO THEIR WORK AREAS.
 - 6) CONDUCT PERIODIC DEPARTMENTAL INSERVICE TRAINING PROGRAMS ON BOMB THREAT AND SEARCH PROCEDURES.

AGITATED PATIENTS: CODE STRONG:

IF A PATIENT UNDER THE CARE OF THE CENTER'S STAFF BECOMES AGITATED OR HOSTILE, THE EMPLOYEES WILL DO THEIR BEST TO CALM THE PATIENT VERBALLY. THIS CAN USUALLY BE ACCOMPLISHED WITH A QUIET MANNER, REASSURANCE, AND/OR NEGOTIATION. IF THE INITIAL EMPLOYEE ATTEMPT IS UNSUCCESSFUL, THE FOLLOWING STEPS SHOULD BE TAKEN:

- VERBALLY OR
- 1) DO NOT PUT YOURSELF IN A COMPROMISING POSITION, EITHER PHYSICALLY.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TITLE: N-110 INTERNAL DISASTER: BOMB THREATS, CODE STRONG

- 2) ENLIST THE HELP OF YOUR CO-WORKERS. OFTEN, A CHANGE OF PERSONALITY WILL DEFUSE THE SITUATION.
- 3) IF UNSUCCESSFUL, NOTIFY YOUR DEPARTMENT MANAGER IMMEDIATELY.
- 4) NOTIFY THE PERSONAL OR HOUSE PHYSICIAN OF THE PROBLEM.
- 5) CONTACT THE ADMINISTRATOR IF NECESSARY.
- 6) IF THE PATIENT IS IN DANGER OF CAUSING PHYSICAL HARM TO SELF OR OTHERS, ANNOUNCE, ANNOUNCE "CODE STRONG" OVER THE INTERCOM AND INDICATE THE LOCATION THAT HELP IS NEEDED.
- 7) ALL AVAILABLE EMPLOYEES, INCLUDING HOUSE PHYSICIANS, WILL RESPOND TO THE SITUATION.
- 8) ENSURE THE SAFETY OF OTHER PATIENTS/VISITORS IN THE AREA BY RELOCATING THEM IF NECESSARY.
- 9) **NEVER** PHYSICALLY RESTRAIN OR ATTEMPT TO MEDICATE THE PATIENT WITHOUT A PHYSICIAN'S ORDER.
- 10) ALWAYS PROTECT THE PATIENT FROM PHYSICAL HARM WHEN USING ANY RESTRAINT DEVICE: PAD ANY PRESSURE POINTS; USE SIDERAIL PADS; DO NOT COMPROMISE RESPIRATIONS/CIRCULATION WITH THE DEVICE; DO NOT LEAVE THE PATIENT UNATTENDED WHEN RESTRAINED.
- 11) RECORD ALL PERTINENT FACTS IN THE MEDICAL RECORD, INCLUDING ANY PHYSICIAN'S ORDERS FOR TREATMENT.
- 12) COMPLETE A VARIANCE REPORT AND FORWARD IT TO THE RISK MANAGER.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TITLE: N-110 INTERNAL DISASTER: BOMB THREATS, CODE STRONG

AGITATED/THREATENING VISITOR/INTRUDER

- 1) DO NOT ARGUE WITH THE PERSON. REMAIN CALM AND TRY NOT TO AGITATE THE PERSON FURTHER.
- 2) NOTIFY YOUR DEPARTMENT MANAGER.
- 3) DO NOT PUT YOURSELF IN A COMPROMISING POSITION, EITHER VERBALLY OR PHYSICALLY.
- 4) IF THE PERSON BECOMES HOSTILE OR PHYSICALLY VIOLENT, DO NOT ATTEMPT TO RESTRAIN THE INDIVIDUAL.
- 5) THE LOCAL POLICE DEPARTMENT SHOULD BE SUMMONDED.
- 6) WHEN THE POLICE OFFICERS ARRIVE, DIRECT THEM TO THE LOCATION OF THE SITUATION. DO NOT ATTEMPT TO ASSIST THEM IN THEIR DUTIES, BUT AVAILABLE TO GIVE THEM INFORMATION.
- 7) IF THE PERSON IS ARMED, COMPLY WITH THEIR DEMANDS AS MUCH AS POSSIBLE. DO NOT PUT YOURSELF IN A DANGEROUS POSITION BY RESISTING. MATERIAL ITEMS CAN BE REPLACED.
- 8) ASSIST YOUR DEPARTMENT MANAGER/THE ADMINISTRATOR TO COMPLETE ANY POLICE REPORTS, VARIANCE REPORTS, OR INSURANCE CLAIMS IF NECESSARY.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

PAGE 5

OF 5

SECTION: N SAFETY
7/03, 11/10, 5/16

DATE: 11/97,

REVIEWED: 3/12

TITLE: N-120 SMOKING POLICY

POLICY: TO MINIMIZE FIRE DANGER AND TO PROMOTE A HEALTHY LIFESTYLE AND ENVIRONMENT WILDCREEK SUREGERY CENTER HAS CREATED A SMOKE FREE CAMPUS. THIS POLICY APPLIES TO ALL EMPLOYEES, VISITORS, PHYSICIANS, AND PATIENTS. SMOKErs WILL BE ASKED TO REFRAIN FROM SMOKING UNTIL THEY HAVE LEFT THE PREMISES.

SECTION: N SAFETY

DATE: 11/97
REVIEWED: 7/14, 5/16

TITLE: N-130 FIRE SAFETY RULES AND REGULATIONS

POLICY: WILDCREEK SURGERY CENTER WILL ENSURE THE SAFETY OF THE PATIENTS, STAFF, AND VISITORS THROUGH THE ENFORCEMENT OF FIRE SAFETY RULES AND REGULATIONS. THE LOCAL, STATE, AND FEDERAL LAWS AND ORDINANCES WILL BE INCLUDED IN THESE RULES.

A) FIRE REGULATIONS:

- 1) SMOKING IS PROHIBITED AT WILDCREEK SURGERY CENTER.
- 2) NO OPEN FLAMES ARE PERMITTED IN OR AROUND COMBUSTIBLE GASES OR ROOMS CONTAINING SUCH.
- 3) WHEN THE FIRE ALARM SOUNDS, ALL EMPLOYEES ARE TO RETURN TO THEIR ASSIGNED AREAS IMMEDIATELY.

B) FIRE ALARM PROCEDURE:

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

1) THE PERSON DISCOVERING THE FIRE IS RESPONSIBLE FOR ACTIVATING THE FIRE ALARM SIGNAL BY PULLING DOWN ON THE FIRE ALARM HANDLE. THESE ALARMS ARE CLEARLY MARKED AND LOCATED THROUGHOUT THE CENTER. THE ALARM HANDLE IS LOCATED IN THE FRONT ENTRY VESTIBULE.

2) THE PERSON DISCOVERING THE FIRE WILL THEN REMOVE ALL PERSONS FROM THE IMMEDIATE DANGER AREA OF THE FIRE, AND WILL CLOSE THE FIRE DOORS TO THE AREA.

3) THE PERSON DISCOVERING THE FIRE WILL THEN NOTIFY THE FRONT DESK RECEPTIONIST OF THE CENTER OF THE LOCATION, TYPE, AND SIZE OF THE FIRE. THIS IS ACCOMPLISHED BY DIALING "0" ON THE NEAREST PHONE.

4) WHEN THE FIRE ALARM SOUNDS, EMPLOYEES IN THEIR DESIGNATED AREAS WILL PROCEED WITH THE FOLLOWING:

A) REMOVE ALL PATIENTS, VISITORS, AND OTHER STAFF MEMBERS FROM IMMEDIATE DANGER.

B) CONTAIN THE FIRE BY CLOSING ALL FIRE DOORS IN THE AREA.

C) IF POSSIBLE, USE THE FIRE EXTINGUISHER TO FIGHT THE FIRE **ONLY** IF IT IS A SMALL FIRE THAT DOES NOT INVOLVE TOXIC CHEMICALS MATERIALS. IF THERE IS ANY DOUBT AS TO YOUR ABILITY TO EXTINGUISH THE FIRE, EVACUATE THE AREA.

5) THE FIRE ALARM SYSTEM IS CONNECTED TO THE ADT ALERT. THE CENTER'S RECEPTIONIST WILL ASSURE DOUBLING COVERAGE BY DIALING 911 AND REPORTING THE FIRE.

C) DESIGNATED AREA PROCEDURE:

1) **BUSINESS OFFICE PERSONNEL:**

A) CALL 911 AND REPORT THE FIRE SIZE, TYPE, AND LOCATION.

B) DIRECT FIREMEN UPON ARRIVAL.

C) RESPONSIBLE FOR EVACUATION OF PATIENTS AND VISITORS FROM THE FRONT WAITING AREA WHEN INDICATED.

2) **PRE-OP/ADMITTING PERSONNEL:**

A) HAVE THE PARENTS OF PEDIATRIC VISITORS WALK WITH OR CARRY THEIR CHILDREN OUT THE NEAREST **SAFE** EXIT WHEN INDICATED.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

B) USE WHEELCHAIRS OR STRETCHERS FOR UNSTEADY OR IMPAIRED PATIENTS.

C) REMAIN WITH THE PATIENTS AT A SAFE DISTANCE FROM THE BUILDING, AWAY FROM THE ENTRANCES WHEN EVACUATION IS INDICATED.

3) OPERATING ROOM PERSONNEL:

A) TURN OFF THE GAS VALVES OF ALL GAS TANKS NOT IN USE.

B) IF SURGERY IS IN PROGRESS, ASSIST THE PHYSICIANS TO SECURE THE SURGERY SITE. OBTAIN, EQUIPMENT AND SUPPLIES FOR TRANSPORT IF THERE IS AN IMMEDIATE DANGER OF FIRE OR SMOKE ENTERING THE OPERATING ROOM.

C) IF THE FIRE IS IN ANOTHER PART OF THE BUILDING AND SAFELY SEPARATED FROM THE OPERATING AREA BY FIRE DOORS, CLOSE THE DOORS AND REMAIN WITH THE PHYSICIANS AND PATIENT.

D) IF MOVING OF THE PATIENT IS REQUIRED, ASSIST THE PHYSICIANS TO DO SO THROUGH THE NEAREST **SAFE** EXIT, OR TO ANOTHER SAFE PART OF THE BUILDING.

E) ENLIST ADDITIONAL HELP AS NEEDED FOR MOVING OF THE PATIENT AND ANESTHESIA MACHINE/EQUIPMENT.

F) IF YOUR ROOM WAS NOT IN USE AT THE TIME OF THE ALARM, REPORT TO THE NURSING MANAGER FOR DIRECTIONS ON WHERE ASSISTANCE IS NEEDED.

G) ASSIST AS NEEDED TO EVACUATE PATIENTS, VISITORS, AND OTHER STAFF MEMBERS.

H) EVACUATION OF ALL PATIENTS AND VISITORS SHOULD BE VIA THE FRONT ENTRANCE AND/OR THE WEST EMERGENCY EXIT IN THE SURGERY CENTER.

4) RECOVERY ROOM PERSONNEL:

A) CLOSE ALL FIRE DOORS.

B) USE PORTABLE OXYGEN TANKS ON PATIENTS THAT STILL REQUIRE OXYGEN ADMINISTRATION.

C) TURN OFF ALL GAS VALVES LOCATED NEAR RECOVERY ROOM.

D) IF THE FIRE IS LOCATED IN ANOTHER PART OF THE BUILDING AND IS SAFELY SEPARATED BY CLOSED FIRE DOORS, AND IF THERE

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

IS NO SMOKE ENTERING THE PACU AREA, REMAIN WITH THE PATIENTS WHILE PREPARING AS MUCH AS POSSIBLE FOR EVACUATION.

E) IF THERE IS SMOKE ENTERING THE PACU AREA, OR IF THE DANGER OF THE FIRE IS IMMEDIATE, EVACUATE PATIENTS THROUGH THE NEAREST **SAFE** EXIT. MOVE AWAY FROM THE BUILDING AND REMAIN WITH THE PATIENTS AT ALL TIMES.

F) WHEN EVACUATING PATIENTS, USE STRETCHERS WHEN POSSIBLE. WHEELCHAIRS AND AMBULATION MAY ALSO BE USED AS EACH PATIENTS CONDITION PERMITS

G) PRE-OPERATIVE PATIENTS WHO HAVE NOT RECEIVED SEDATION MAY BE AMBULATED OUT OF THE BUILDING IF THEIR CONDITION PERMITS.

5) ADMINISTRATOR/NURSE MANAGER

A) RESPOND TO AREA OF FIRE IMMEDIATELY AND DETERMINE IF EVACUATION OF AREA IS NECESSARY.

B) ADVISE RECEPTIONIST OF PLAN OF ACTION SO THAT SHE/HE CAN NOTIFY APPROPRIATE PERSONNEL.

C) ASSIST WITH CARE OF PATIENTS/STAFF IN IMMEDIATE DANGER.

D) ASSURE THAT ALL PERSONS IN THE BUILDING HAVE SAFELY BEEN EVACUATED.

E) ASSIST FIRE DEPARTMENT REPRESENTATIVE WITH ANY PERTINENT INFORMATION.

F) ASSURE THAT STAFF IS RESPONSIVE TO PHYSICAL AND EMOTIONAL NEEDS OF PATIENTS AND VISITORS.

G) CONDUCTS POST FIRE DE-BRIEFING OF STAFF, PERFORMS AN EVALUATION OF CAUSE OF FIRE AND RESPONSE OF STAFF AND EMERGENCY PERSONNEL.

H) NOTIFICATION OF MANAGEMENT PERSONNEL, SAFETY AND RISK MANAGEMENT COMMITTEES AND OUTSIDE AGENCIES AS APPROPRIATE.

D) IMPORTANT POINTS FOR ALL STAFF MEMBERS:

1) PREVENT FIRES:

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

GOOD HOUSEKEEPING AND OBSERVING RULES ARE THE BEST DETERRENT FOR FIRES. MAKE IT A HABIT TO WATCH FOR FIRE HAZARDS AND REPORT ANY POSSIBLE DANGERS TO YOUR DEPARTMENT MANAGER.

2) KNOW THE LOCATION OF ALARMS, EXITS, AND EXTINGUISHERS:

BE AWARE OF YOUR NEAREST ALARMS, EXITS, AND EXTINGUISHERS IN YOUR ASSIGNED WORK PLACE. REVIEW THE ESCAPE ROUTE WITH YOUR DEPARTMENT MANAGER IF YOU ARE UNSURE OF THE EXIT LOCATIONS. PARTICIPATE IN PRACTICES AND DRILLS, AND KNOW HOW TO USE THE EQUIPMENT.

3) AVOID PANIC:

THE GREATEST DANGER IN MOST FIRES IS **PANIC**. IF YOU REMAIN CALM, SO WILL YOUR CO-WORKERS. A QUIET, ASSURING MANNER WILL KEEP PATIENTS AND VISITORS CALM. THE PUBLIC WILL LOOK TO YOU FOR GUIDANCE, AND WILL **PANIC** IF YOU DO. **NEVER** SHOUT "**FIRE**", AS THIS IS A SURE INVITATION FOR CHAOS.

4) KNOW YOUR ASSIGNED DUTIES IN A FIRE ALARM:

DON'T SCOFF AT FIRE DRILLS OR REHEARSALS, PEOPLE'S LIVES ARE AT STAKE AND MAY DEPEND ON YOUR ACTIONS TO SAVE THEM. REVIEW THE FIRE PLAN FOR YOUR AREA, AND LEARN HOW TO USE THE FIRE EXTINGUISHERS. ATTEND ALL IN-SERVICES AND ASK FOR YOUR DEPARTMENT MANAGER'S ASSISTANCE IF YOU ARE UNSURE OF ANY PART OF THE PLAN. **BE PREPARED!!**

5) BE ALERT FOR SIGNS OF FIRE:

IF YOU SEE OR SMELL SMOKE INVESTIGATE AND REPORT IT AT ONCE. EVERY SECOND COUNTS IN A FIRE, AND THE FASTER IT IS CONTAINED, THE LESS DAMAGE AND LOSS IT IS LIKELY TO CAUSE.

6) FIRE DRILLS WILL BE CONDUCTED QUARTERLY:

PER NEVADA STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES FIRE DRILLS WILL BE CONDUCTED AND DOCUMENTED ON A QUARTERLY BASIS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: n SAFETY
7/03

DATE: 11/97,

REVIEWED: 3/12, 5/16

TITLE: N-140 SAFETY RULES AND REGULATIONS (GENERAL)

POLICY:

IT is the policy of wildcreek surgery center to provide a safe, HEALTHFUL, and sanitary working environment for patients, staff, and visitors. Standards shall be set and maintained according to local, STATE AND federal rules, laws, and regulations. It is one of the objectives of THE CENTER to comply with all rules, mandates, laws, and regulations pertaining to the safety and health of its employees.

PROCEDURE:

Each Department Manager is responsible for developing specific written safety rules and regulations. These rules and regulations must be a part of the introduction and orientation of each new employee brought into the department. Safety systems will be developed and maintained through policies and procedures to minimize hazards to patients, staff, and visitors. Guidelines for all employees include the following:

1) Know the safety rules and regulations for both department and those applicable to the operation of the Center.

2) Know the location and operation of the Center's telephones, fire extinguishers, exits, and your individual responsibilities in case of fire, bomb THREAT or disaster.

3) Report immediately to your supervisor hazards or violations of safety standards, such as in the following examples:

- a) Defective equipment;
- b) Careless use of equipment;

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

c) Obstruction to exit doors, corridors, entry ways or entry doors to patient rooms, offices, or departments;
d) Smoking in unauthorized areas;
e) Wet or slippery floors;
f) Combustible materials near heat or open flames.

4) Observe safety standards in the use of wheelchairs, stretchers, beds, or other equipment related to patient care.

PAGE 1 OF

3

SECTION: n SAFETY
7/03

DATE: 11/97,

REVIEWED: 3/12, 5/16

TITLE: N-140 SAFETY RULES AND REGULATIONS (GENERAL)

5) Observe the basic rules for lifting patients. Proper body mechanics should be used when lifting or moving patients. Request assistance as necessary.

6) Use care when approaching swinging doors, congested areas, or turning corners. "NEVER RUN".

7) Report unauthorized individuals NEAR OR IN THE FACILITY

8) Do not operate equipment unless you have been properly INSTRUCTED.

9) UNPROFESSIONAL CONDUCT WILL NOT BE ALLOWED

10) Follow safety precautions in disposing of all types of needles or other sharp items in the appropriate sharps puncture resistant containers.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

11) Injury related accidents are to be reported immediately to your supervisor.

12) Operate tools and equipment only after instructions and proper demonstration of proficiency.

13) Use protective clothing/equipment where indicated, i.e., gowns, masks, gloves, eye shields, etc.

14) CLEAN SPILLS IMMEDIATELY.

15) Dispose of sharp objects, contaminated trash, or hazardous materials in the proper CONTAINERS.

16) FOLLOW PROTOCOL FOR HANDWASHING.

17) Never operate or use electrical equipment that is not properly grounded, HAS FRayed cords, or is MALFUNCTIONING IN ANY WAY.

PAGE

2 OF 3

SECTION: n SAFETY
7/03

DATE: 11/97,

REVIEWED: 3/12, 5/16

TITLE: N-140 SAFETY RULES AND REGULATIONS (GENERAL)

18) MALFUNCTIONING OR BROKEN EQUIPMENT SHOULD BE IMMEDIATELY REMOVED FROM

USE, APPROPRIATELY LABELED, REPORTED TO THE SUPERVISOR AND SUBMITTED FOR

REPAIR WITH A LOCK-OUT TAG.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

3

PAGE 3 OF

SECTION: N SAFETY
7/03

DATE: 11/97,

REVIEWED: 3/12, 5/16

TITLE: N-150 SAFETY FOR OFFICE AREAS

WILDCREEK SURGERY CENTER WILL ENSURE THAT THE CENTER IS MAINTAINED IN A SAFE AND ORDERLY MANNER.

PROCEDURE:

THE INDIVIDUALS WORKING IN THE OFFICE AREAS OF THE CENTER WILL MAINTAIN AN ENVIRONMENT FREE OF SAFETY HAZARDS. THESE PERSONS WILL BE COGNIZANT OF SAFETY ISSUES THAT ARE PRESENTED ON A DAY TO DAY BASIS WITHIN THEIR WORKING AREAS. ALL OFFICE WORKERS WILL BE RESPONSIBLE FOR THE FOLLOWING:

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- 1) DESK AND COUNTER TOPS SHOULD BE FREE OF SHARP CORNERS.
- 2) MATERIALS SHOULD BE EVENLY DISTRIBUTED IN FILE CABINETS SO THAT THE UPPER DRAWERS DO NOT UNBALANCE THE FILE AND CAUSE THE FILE TO FALL OVER.
- 3) ONLY ONE FILE DRAWER SHOULD BE OPEN AT A TIME, AND EACH DRAWER WILL BE CLOSED AFTER USE.
- 4) PAPERS AND OTHER MATERIALS SHOULD BE KEPT OFF THE FLOORS AND OUT OF PATHWAYS.
- 5) ALL ELECTRICAL EQUIPMENT WILL BE PROPERLY GROUNDED.
- 6) HEAVY MATERIALS WILL BE STORED CLOSE TO THE GROUND, NEVER ON HIGH SHELVES OR ABOVE PATHWAYS.
- 7) ANY DEFICIENCIES OF THE ABOVE WILL BE REPORTED IMMEDIATELY TO THE APPROPRIATE DEPARTMENT MANAGER.
- 8) IN THE EVENT OF A FACILITY EMERGENCY, SUCH AS FIRE, IT WILL BE THE RESPONSIBILITY OF THE BUSINESS OFFICE MANAGER TO TRANSFER ALL PATIENT MEDICAL RECORDS TO A DESIGNATED AREA FOR SAFE KEEPING. IN THE ABSENCE OF THE BUSINESS OFFICE MANAGER, THE MEDICAL RECORDS COORDINATOR WILL ASSUME THIS RESPONSIBILITY.

SECTION: N SAFETY
7/03

DATE: 11/97,
REVIEWED: 3/12, 5/16

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TITLE: N-160 SAFE MEDICAL DEVICES ACT (SMDA)

WILDCREEK SURGERY CENTER WILL SUPPORT AND COMPLY WITH THE SAFE MEDICAL DEVICES ACT (SMDA) WHICH BECAME EFFECTIVE ON NOVEMBER 28, 1991. THIS ACT REQUIRES THAT HEALTHCARE FACILITIES UTILIZING MEDICAL DEVICES WHICH HAVE CAUSED PATIENT CERTAIN ADVERSE OUTCOMES, TO REPORT SUCH EVENTS TO THE FDA AND/OR MANUFACTURER

PROCEDURE:

1) A MEDICAL DEVICE IS DEFINED AS AN INSTRUMENT, IMPLEMENT, MACHINE, APPARATUS, IMPLANT, OR OTHER SIMILAR OR RELATED ARTICLE INTENDED FOR USE IN DIAGNOSIS, CURE, TREATMENT, OR PREVENTION OF DISEASE. (PHARMACEUTICALS ARE NOT INCLUDED).

EXAMPLES: ANESTHESIA MACHINES, DEFIBRILLATORS, CATHETERS, INTRAOCULAR LENSES, BLOOD GLUCOSE MONITORS, BREAST IMPLANTS, X-RAY MACHINES, AND LASERS TO NAME A FEW.

2) A REPORT WILL BE FILED WHEN INFORMATION EXISTS THAT REASONABLY SUGGESTS THERE IS A PROBABILITY THAT A DEVICE HAS CAUSED OR CONTRIBUTED TO THE DEATH, SERIOUS INJURY, OR SERIOUS ILLNESS OF A PATIENT.

3) THE REPORT WILL BE MADE WITHIN 10 WORKING DAYS AFTER BECOMING AWARE

OF A REPORTABLE EVENT.

4) A SEMI-ANNUAL SUMMARY WILL BE MADE EVERY JANUARY AND JULY IF THE CENTER HAS EXPERIENCED A REPORTABLE EVENT.

5) THE REPORT WILL BE MADE TO THE FDA IN THE CASE OF A DEATH. THE REPORT WILL BE MADE TO THE MANUFACTURER IN THE CASE OF SERIOUS INJURY OR ILLNESS. IF THE MANUFACTURER IS UNKNOWN, THEN THE REPORT WILL BE MADE TO THE FDA.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- 6) SEMI-ANNUAL REPORTS WILL BE MADE TO THE FDA:

FOOD AND DRUG ADMINISTRATION
CENTER FOR DEVICES AND RADIOLOGICAL HEALTH
FDA USER REPORT
P.O. BOX 3002
ROCKVILLE, MD. 20847-3002

SECTION: N SAFETY
7/03

DATE: 11/97,

REVIEWED: 3/12, 5/16

TITLE: N-160 SAFE MEDICAL DEVICES ACT (SMDA)

REPORT TO INCLUDE:
FACILITY NAME AND ADDRESS
PRODUCT, SERIAL NUMBER, MODEL NUMBER
MANUFACTURER AND ADDRESS
BRIEF DESCRIPTION OF EVENT

- 7) FDA REPORTING FORM WILL BE KEPT IN THE QA/RM OFFICE.

- 8) THE RISK MANAGEMENT NURSE, NURSE MANAGER, ADMINISTRATOR,
AND MEDICAL DIRECTOR WILL WORK TOGETHER TO PROPERLY
COMPLETE THE REPORTING FORM.

- 9) ANY DEVICE REPORTABLE WILL BE REMOVED FROM THE PATIENT CARE AREA AND LABELED "DEFECTIVE". THE DEVICE WILL NOT BE USED AGAIN UNTIL SERVICING HAS BEEN COMPLETED. THE DEVICE WILL BE EVALUATED BY AN INDEPENDENT BIOMEDICAL CONSULTANT BEFORE REPAIR AND WRITTEN EVALUATION SUBMITTED TO THE CENTER. THIS EVALUATION WILL BE ATTACHED TO THE FDA REPORTING FORM AND TO THE VARIANCE REPORT.

SECTION: N SAFETY

DATE: 7/03

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

REVIEWED: 3/12,

5/16

TITLE: N-170 EXTENSION CORD USE

POLICY:

WILDCREEK SURGERY CENTER WILL COMPLY WITH FIRE AND SAFETY REGULATIONS TO ENSURE A SAFE WORKING ENVIRONMENT.

PROCEDURE:

1. EXTENSION CORD USE WILL BE LIMITED TO ONLY NECESSARY SITUATIONS.
2. ONLY GROUNDED (THREE PRONG) EXTENSION CORDS WILL BE UTILIZED.
3. EXTENSION CORDS WILL BE RATED WITH AS GREAT OR GREAT ELECTRICAL CAPACITY AS THE UNIT IT IS BEING CONNECTED WITH.
4. CARE WILL BE TAKEN THAT THE EXTENSION CORD IS NOT EXPOSED TO SPILL OR POOLING OF FLUIDS.

SECTION: N SAFETY
8/12

DATE: 11/97, 12/10,

REVIEWED: 3/12, 5/16

TITLE: N-180 EYE WASH STATIONS

POLICY: WILDCREEK SURGERY CENTER WILL PROVIDE AND MAINTAIN A MEANS TO FLUSH THE EYES IN A SITUATION WHERE THE EYES HAVE BEEN SUBJECTED TO GASSES, SOLUTIONS, OR DEBRIS CAPABLE OF PRODUCING INJURY.

PROCEDURE:

- 1) EYE WASH STATIONS WILL BE ESTABLISHED AND MAINTAINED IN THE CENTER (CURRENTLY ONE STATION IS ESTABLISHED).
- 2) SIGNS WILL BE POSTED DESIGNATING THE EYE WASH STATION.
- 3) OPERATION OF EYEWASH STATION:

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

--TURN WATER FAUCET ON
--PUSH BUTTON ON FAUCET OUTWARD
--LEAN OVER SINK AND ALLOW STREAM OF WATER TO
FLUSH
EYES
--15 MINUTE FLUSH IS RECOMMENDED

4) MAINTENANCE

--THE STATION WILL BE CHECK
DAILY AND DOCUMENTED ON THE CRASH
CRASHCART CHECK LIST
--PLASTIC PROTECTIVE COVERS WILL BE REPLACED WHEN
LOST
OR DAMAGED.

SECTION: N SAFETY

DATE: 11/97, 7/03, 3/11, 12/16
REVIEWED: 3/12, 5/16

TITLE: N-190 HAZARDS, RECALLS AND ALERTS

POLICY: THE NURSING MANAGER OF WILDCREEK SURGERY CENTER WILL
BE RESPONSIBLE FOR ALL HAZARDS, RECALLS, AND ALERTS. THIS
PERSON WILL COLLECT AND REVIEW ALL DATA CONCERNING
DEFECTIVE EQUIPMENT, SUPPLIES, MEDICATIONS AND FOOD PRODUCTS
WHICH MAY EFFECT THE GENERAL SAFETY OR PRESENT A RISK TO PATIENT
CARE, VISITORS, OR CENTER STAFF.

PROCEDURE: THE NURSE MANAGER WILL:

- REVIEW ALL DATA COLLECTED FROM ALL SOURCES CONCERNING RECALLS OR ALERTS OF DEFECTIVE OR HAZARDOUS EQUIPMENT, SUPPLIES, MEDICATIONS AND FOOD PRODUCTS.
- TAKE IMMEDIATE ACTION AS NECESSARY TO PROVIDE THE PROPER PROTECION OF ALL PATIENTS, VISITORS, AND STAFF MEMBERS. REMOVE RECALLED EQUIPMENT, SUPPLIES, MEDICATION, OR FOOD PRODUCT FROM PATIENT USE AREA IMMEDIATELY.
- FOLLOW MANUFACTURER OR DISTRIBUTERS INSTRUCTION AS TO DISPOSITION OF RECALLED PRODUCT.
- INFORM THE CENTER'S ADMINISTRATOR AND MEDICAL DIRECTOR.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- DISSEMINATE HAZARDOUS RECALL OR ALERT INFORMATION TO APPROPRIATE STAFF MEMBERS INVOLVED IN THE UTILIZATION OF THE POTENTIAL HAZARDOUS EQUIPMENT, SUPPLIES, MEDICATIONS AND FOOD PRODUCTS.
- COLLECT, COORDINATE, AND EVALUATE INFORMATION RETURNED FROM THE INVOLVED AREAS TO ASSURE THAT ANY ACTION REQUIRED HAS BEEN ADDRESSED AND HANDLED TO MINIMIZE RISK ASSOCIATED WITH THE ITEM IN QUESTION.
- MONITOR ALL OUTSTANDING RECALLS TO ASSURE THAT ALL ISSUES OR POTENTIAL PRODUCT LIABILITIES HAVE BEEN RESOLVED TO COMPLETION.
- MAINTAIN SUPPORTING DOCUMENTATION WITHIN THE CENTER.
- REPORT RESULTS INCLUDING ANY ACTIONS TAKEN TO THE QAPI COMMITTEE.
- CALL IN OTHER PERSONNEL AS NEEDED TO ASSIST IN FINDING RESOLUTIONS TO IDENTIFIED ISSUES AS NECESSARY THIS PERSON WILL COLLECT AND REVIEW CONCERNING DEFECTIVE EQUIPMENT SUPPLIES, MEDICATIONS AND FOOD PRODUCTS WHICH MAY EFFECT PATIENTS, VISITORS, OR CENTER STAFF.

SECTION: N SAFETY
7/03, 8/12

DATE: 11/97,

REVIEWED: 3/12, 5/16

TITLE: N-200 MEDICAL WASTE MANAGEMENT

POLICY:

WILDCREEK SURGERY CENTER will comply with all local, STATE, AND federal laws, rules, and regulations governing the handling and disposal of contaminated medical waste. The Center will protect all employees, visitors, and staff members from possible exposure to infectious diseases through a waste management program. In addition, the Center will protect the public and the environment in general by containing all contaminated wastes prior to their disposal so as not to cause infectious disease to be spread. These contaminated wastes will be contained and disposed of in a safe and approved manner.

PROCEDURE:

DEFINITION-INFECTIOUS MEDICAL WASTE:

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

Biohazardous waste is any solid or liquid waste which may present a threat of infection to humans. The requirements for induction of disease is the presence of a pathogen with sufficient virulence and in a quantity substantial enough so that exposure to the waste by a susceptible host or organism could result in an infectious disease.

IDENTIFICATION OF MEDICAL WASTE:

Isolation waste from patients with infectious disease Cultures and stocks of infectious agents and associated biologicals Human blood and blood products; used, absorbent materials such as bandages, sponges, and gauze supersaturated with blood or body fluids having the potential to drip or splash

Pathological waste; tissues, organs, or body parts

Contaminated sharps; hypodermic needles, syringes, pipettes, broken glass, scalpel blades, suturing needles, TROCARS, etc.

1) The Nurse Manager will be responsible for the development and maintenance of a Medical Waste Management Program.

2) The Waste Management Program will include:

- a) Employee training in medical waste handling
- b) Monitoring of proper packaging and labeling
- c) Follow-through on tracking procedures
- d) Contingency/emergency plan

PAGE

1 OF 3

SECTION: N SAFETY
7/03, 8/12

DATE: 11/97,

3/15, 5/16

REVIEWED: 3/12,

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TITLE: N-200 MEDICAL WASTE MANAGEMENT

- 3) All potentially infectious medical waste will be separated from general facility garbage at its point of origin.
- 4) All potentially infectious medical waste will be placed in boxes labeled "Biohazard Waste" that conspicuously displayed the Biohazard symbol. These boxes will be lined with two (2) red plastic bags that are impervious tear resistant, and with seams that are of equal resistance to tearing and leaking.
- 5) Each Hazardous Waste Box will not exceed a fifty (50) pound maximum weight limit.
- 6) All fluids placed in the Hazardous Waste Box will be CONTAINED; CAPS will be placed securely on all ports of suction containers. Bulk blood, suctioned fluids excretions, and secretions may be carefully poured down a drain connected to sanitary sewer.
- 7) NEEDLES WILL NOT BE BENT BROKEN OR RECAPPED AND WILL BE PLACED IN APPROVED SHARPS CONTAINERS IMMEDIATELY AFTER USE. All sharps will first be placed in a puncture proof sharps container. When filled, the sharps container will be securely closed AND LOCED IN THE BIOHAZARD CABINET UNTIL PICK-UP
- 8) Filled Hazardous Waste Boxes will be secured by folding the inner red bag over the contents, then twisting the outer red bag closed and securely with a tie. The lid must be able to fit snugly on to the box, boxes will not be overfilled.
- 9) Secured Hazardous Waste Boxes will be LOCKED IN THE BIO-HAZARD CABINET until pick-up. this area has been designated for contaminated waste containers, and has restricted access by unauthorized persons.
- 10) Pick-up will be arranged on an AS NEEDED basis.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

2 OF 3

PAGE

SECTION: N SAFETY
7/03, 8/12

DATE: 11/97,

REVIEWED: 3/12, 5/16

TITLE: N-200 MEDICAL WASTE MANAGEMENT

- 11) In the event of leakage or accidental spill of a Hazardous Waste Box, protective attire will be worn and the contents will be placed in an intact BIO-Hazardous Waste Box. Spills will be cleaned up using a germicidal agent and disposable towels. All materials used in cleaning the spill will then be disposed of in a Hazardous Waste Box; saturated or dripping materials will first be placed in a plastic bag.
- 12) Transportation of the filled Hazardous Waste Boxes off the premises will be by enclosed, leak proof trucks.
- 13) Documentation of pick-up will be maintained by the Center; documentation of appropriate disposal will be maintained by the receiving service as well as tracking of Center volume.
- 14) WASTE MANAGEMENT is a state approved BIO-Hazardous Waste Disposal Service, and will be utilized for the collection of WILDCREEK SURGERY CENTER bio-Hazardous Waste.
- 15) Policies and Procedures relating to the operation of the hazardous materials and waste management system will be reviewed annually.
- 16) The Quality IMPROVEMENT/Risk Management Committee will be responsible for tracking the management of bio-

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

hazardous waste, securing regulations, and maintaining communication for operation of service with b & l disposal.

PAGE 3 OF

3

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16

TITLE: N-210 HAZARDOUS MATERIALS COMMUNICATION PROGRAM

POLICY: WILDCREEK SURGERY CENTER WILL MAINTAIN AN UP TO DATE PROGRAM FOR THE PURPOSE OF COMMUNICATING TO EMPLOYEES ON HAZARDOUS CHEMICALS IN THE WORK PLACE.

PROCEDURE:

RECORD KEEPING:

- 1) **MATERIAL SAFETY DATA SHEETS:**
THESE WILL BE KEPT UP TO DATE WITH ALL CURRENT AND ANY NEW CHEMICALS IN THE CENTER.
- 2) **EMPLOYEE SIGN OFF SHEETS:**
WHEN EMPLOYEES ATTEND THE HAZARDOUS COMMUNICATIONS PROGRAM AS PART OF THEIR ORIENTATION, THEY WILL SIGN AND DATE A FORM ACKNOWLEDGING THIS. THESE COMPLETED FORMS WILL BE KEPT IN PERSONNEL FILES
- 3) **RESPONSIBILITIES:**

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

THE CENTER'S NURSING MANAGER WILL BE RESPONSIBLE FOR ASSURING THAT ALL EMPLOYEES RECEIVE THE HAZARDOUS MATERIAL INFORMATION.

SECTION: N SAFETY

DATE: 11/97, 7/03, 9/09

REVIEWED: 3/12, 5/16

TITLE: N-220 HAZARDOUS MATERIALS EDUCATION, ORIENTATION, AND TRAINING

POLICY: WILDCREEK SURGERY CENTER WILL PROVIDE THE EMPLOYEES WITH INFORMATION AND TRAINING ON HAZARDOUS MATERIALS IN THE WORK AREA AT THE TIME OF EMPLOYMENT AND WHEN NEW HAZARDOUS MATERIALS ARE INTRODUCED INTO HIS/HER WORK AREAS.

ACTION: THE EMPLOYEE WILL BE ABLE TO IDENTIFY AND VERBALIZE:

1. THE LOCATION AND STORAGE OF POTENTIALLY HAZARDOUS MATERIALS IN THE WORK AREA.
2. THE PHYSICAL AND HEALTH HAZARDS OF MATERIALS IN THE WORK AREA.
3. THE LABELING INFORMATION REQUIRED ON ALL POTENTIALLY HAZARDOUS MATERIALS.
4. THE MEASURES TO BE TAKEN TO PROTECT HIM/HER FROM EXPOSURE TO HAZARDOUS MATERIALS, SUCH AS APPROPRIATE WORK PRACTICES, EMERGENCY PROCEDURES AND THE PERSONAL PROTECTIVE EQUIPMENT TO BE USED.
5. LOCATION OF SAFETY AIDS SUCH AS SHOWERS, EYE WASH STATIONS, FIRE EXTINGUISHERS, ETC.
6. LOCATION AND CONTENT OF THE MATERIAL SAFETY DATA SHEET (MSDS) .
7. THE REQUIREMENT OF COMPLETION OF THE HAZARDOUS COMMUNICATION PROGRAM AT THE TIME OF EMPLOYMENT AND ANNUALLY.

DATE _____ SIGNED _____

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WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

DATE _____ SIGNED _____

DATE _____ SIGNED _____

SECTION: N SAFETY

DATE: 11/97, 7/03, 5/16

REVIEWED: 3/12

TITLE: N-230 HAZARDOUS MATERIALS SPILL OR ACCIDENT

POLICY: WILDCREEK SURGERY CENTER WILL PROTECT ALL PATIENTS, VISITORS, AND STAFF MEMBERS FROM THE POTENTIAL DANGERS OF A HAZARDOUS MATERIAL SPILL BY FOLLOWING THE PROCEDURE LISTED BELOW.

PROCEDURE: 1) REGULAR INSPECTIONS WILL BE MADE OF THE STORAGE SITES FOR ALL HAZARDOUS MATERIALS. THESE INSPECTIONS WILL BE MADE FOR THE PURPOSE OF DETECTING ANY LEAKING OR SPILLED CONTAINERS. IF ANY LEAKS OR SPILLS ARE FOUND, THE FOLLOWING STEPS WILL BE TAKEN:

2) BEFORE ATTEMPTING TO CLEAN UP ANY HAZARDOUS CHEMICAL SPILL, KNOW WHAT THE CHEMICAL IS!

3) OBTAIN THE MATERIAL SAFETY DATA SHEET (MSDS) FOR THAT PARTICULAR PRODUCT. THE MATERIAL SAFETY DATA SHEETS ARE KEPT CLEARLY MARKED BINDERS IN THE ANESTHESIA WORK ROOM.

4) FOLLOW THE DIRECTIONS ON THE MSDS FOR THAT PRODUCT TO ACQUIRE THE PROPER PROTECTIVE CLOTHING/EQUIPMENT AND TO CLEAN UP THE LEAK OR SPILL.

5) ENSURE ADEQUATE VENTILATION FOR THE TASK.

6) IF NECESSARY, EVACUATE ALL PERSONS FROM THE AREA BEFORE DOING THE CLEAN UP.

7) IF A FIRE OCCURS, PROCEED WITH THE FIRE ALARM PROCEDURE (SEE "FIRE SAFETY RULES AND REGULATION").

8) AVOID TRACKING THROUGH THE SPILL DURING THE CLEAN UP.

9) COMPLETE A VARIANCE REPORT ON THE LEAK OR SPILL.

10) NOTIFY THE NURSING MANAGER OF ALL LEAKS/SPILLS.

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

TITLE: N-240 HAZARDOUS MATERIALS

POLICY:

WILDCREEK SURGERY CENTER WILL COMPLY WITH ALL LOCAL, STATE, AND FEDERAL RULES AND REGULATIONS GOVERNING THE USE, HANDLING, AND STORAGE OF ALL HAZARDOUS MATERIALS. THE CENTER'S RISK MANAGEMENT COMMITTEE IS RESPONSIBLE FOR DEVELOPING AND IMPLEMENTING A CENTER-WIDE HAZARDOUS MATERIAL SAFETY PROGRAM WHICH WILL INCLUDE:

- 1) IDENTIFICATION OF HAZARDOUS MATERIALS USED WITHIN THE CENTER.
- 2) MAINTAIN AND MONITOR APPROPRIATE MATERIAL SAFETY DATA SHEETS ON ALL MATERIAL THAT IS CONSIDERED HAZARDOUS.
- 3) TRAINING OF EMPLOYEES WHO HANDLE OR ARE EXPOSED TO THE HAZARDOUS MATERIALS WITH EMPHASIS ON SAFETY ASPECTS ASSOCIATED WITH THE HAZARDOUS MATERIALS.
- 4) IMPLEMENTATION AND ON-GOING MONITORING OF THE HAZARDOUS MATERIAL POLICY.

PROCEDURE: EMPLOYEE INFORMATION AND TRAINING:

THE CENTER'S DEPARTMENT MANAGERS WILL PROVIDE THEIR EMPLOYEES WITH INFORMATION AND TRAINING ON HAZARDOUS CHEMICALS IN THEIR WORK AREA AT THE TIME OF THEIR INITIAL ASSIGNMENT, AND WHENEVER A NEW HAZARD IS INTRODUCED INTO THEIR WORK AREA. INFORMATION AND TRAINING WILL CONSIST OF THE FOLLOWING:

- A) THE REQUIREMENTS OF THIS POLICY;
- B) ANY OPERATIONS IN THEIR WORK AREA WHERE HAZARDOUS MATERIALS ARE PRESENT;
- C) THE LOCATION AND AVAILABILITY OF WRITTEN HAZARD COMMUNICATIONS, INCLUDING THE REQUIRED LIST OF HAZARDOUS MATERIALS AND MATERIAL SAFETY DATA SHEETS REQUIRED BY THIS POLICY;
- D) METHODS AND OBSERVATIONS THAT MAY BE USED TO DETECT THE PRESENCE OR RELEASE OF A HAZARDOUS MATERIAL INTO THEIR WORK AREA;
- E) THE PHYSICAL AND HEALTH HAZARDS OF THE MATERIALS IN THE WORK AREA;

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16

TITLE: N-240 HAZARDOUS MATERIALS

- F) THE MEASURES EMPLOYEES CAN TAKE TO PROTECT THEMSELVES FROM THESE HAZARDS, INCLUDING SPECIFIC PROCEDURES THE EMPLOYER HAS IMPLEMENTED TO PROTECT EMPLOYEES FROM EXPOSURE TO HAZARDOUS MATERIALS, SUCH AS APPROPRIATE WORK PRACTICES, EMERGENCY PROCEDURES, AND PERSONAL PROTECTIVE EQUIPMENT TO BE USED.
- G) THE DETAILS OF THE HAZARD COMMUNICATIONS PROGRAM DEVELOPED BY THE EMPLOYER, INCLUDING AN EXPLANATION OF THE LABELING SYSTEM AND THE MATERIAL SAFETY DATA SHEET, AND HOW EMPLOYEES CAN OBTAIN AND USE THE APPROPRIATE HAZARD INFORMATION;
- H) DOCUMENTATION IN EACH EMPLOYEE'S FILE THAT THE ABOVE MATERIAL HAS BEEN DISCUSSED AT LEAST ON AN ANNUAL BASIS.

2) DEFINITION AND RESPONSIBILITIES:

- A) A HAZARDOUS MATERIAL IS DEFINED AS ANY CHEMICAL THAT IS TOXIC, FLAMMABLE, CORROSIVE, REACTIVE, OR CAPABLE OF CAUSING HARM OR SERIOUS INJURY TO HUMANS, ANIMALS, OR THE ENVIRONMENT.
- B) THE ADMINISTRATOR AND DEPARTMENT MANAGERS HAVE THE AUTHORITY TO INSTITUTE THE EMERGENCY PLAN IN THE EVENT OF A MAJOR CHEMICAL WASTE ACCIDENT OR SPILL OF A HAZARDOUS MATERIAL.
- C) A MATERIAL SAFETY DATA SHEET (MSDS) IS REQUIRED AND COMPLETED BY ALL VENDORS. MSDS'S ARE MAINTAINED WITHIN EACH DEPARTMENT ON EVERY CHEMICAL USED WITHIN THEIR AREA.
- D) A MASTER FILE OF ALL THE MSDS'S IS TO BE MAINTAINED BY THE RISK MANAGEMENT NURSE AND THE SPARKS FIRE DEPARTMENT FOR USE IN THE EVENT OF A HAZARDOUS CHEMICAL SPILL, SPLASH, BURN, OR OTHER ACCIDENTS.
- E) IT IS THE RESPONSIBILITY OF THE DEPARTMENT USING THE HAZARDOUS MATERIAL TO DETERMINE IF A LESS HAZARDOUS ONE MAY BE SUBSTITUTED.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- F) ALL PERSONS REQUIRED TO HANDLE THE HAZARDOUS CHEMICALS OR MATERIALS WILL BE PROVIDED WITH APPROPRIATE ORIENTATION, EQUIPMENT, AND ON THE JOB TRAINING.

PAGE 2

OF 12

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16

TITLE: **N-240 HAZARDOUS MATERIALS**

- G) EACH DEPARTMENT THAT GENERATES OR HANDLES CHEMICAL WASTE WILL HAVE WRITTEN, SPECIFIC POLICIES AND PROCEDURES THAT CONTAIN INFORMATION PERTINENT TO THAT DEPARTMENT. THESE POLICIES AND PROCEDURES WILL BE REVIEWED ANNUALLY AND APPROVED BY THE QA COMMITTEE.

HAZARDOUS MATERIALS RIGHT TO KNOW:

OSHA MAINTAINS A REGULATION TO PROTECT EMPLOYEES FROM POSSIBLE ADVERSE EFFECTS OF POTENTIALLY HAZARDOUS CHEMICALS THEY MAY ENCOUNTER IN THE WORK PLACE. EMPLOYEES WILL BE PROVIDED WITH INFORMATION REGARDING:

- A) THE POTENTIALLY HAZARDOUS CHEMICALS THEY MAY COME INTO CONTACT WITH IN THEIR WORK AREA;
- B) THE NATURE OF THE POTENTIALLY HAZARDOUS CHEMICALS WITH WHICH THEY WORK;
- C) THE PERSONAL PROTECTIVE EQUIPMENT THAT SHOULD BE WORN IN DEALING WITH CHEMICALS;
- D) WHERE THEY CAN GO FOR ADDITIONAL INFORMATION ABOUT THE CHEMICALS THEY MAY ENCOUNTER;
- E) STORAGE OF POTENTIALLY HAZARDOUS CHEMICALS;
- F) LOCATION OF EXISTING SAFETY AIDS SUCH AS SHOWERS, EYE WASHES, ETC.

LABELING INFORMATION:

THE FOLLOWING LABELING INFORMATION IS REQUIRED ON ALL POTENTIALLY HAZARDOUS MATERIALS:

- A) CHEMICAL NAME;

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- B) CHEMICAL ABSTRACT NUMBER ("CAS"), A UNIQUE NUMBER ASSIGNED BY THE FEDERAL GOVERNMENT TO EACH CHEMICAL;
- C) APPROPRIATE HAZARD WARNINGS (FIRE, REACTIVITY, HEALTH);

PAGE 3 OF 12

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16

TITLE: **N-240 HAZARDOUS MATERIALS**

- D) TARGET ORGAN INFORMATION, SUCH AS THE SPECIFIC ORGAN OR ORGAN GROUPS THAT EXPOSURE TO THE CHEMICAL MAY EFFECT;
- E) IN SOME CASES, THE PERSONAL PROTECTIVE EQUIPMENT TO BE USED IN HANDLING THE CHEMICAL IS STATED.

MATERIAL SAFETY DATA SHEETS:

ALL MATERIAL SAFETY DATA SHEETS WILL CONTAIN THE FOLLOWING INFORMATION IF APPLICABLE:

- A) IDENTITY: WHO MAKES IT, THEIR ADDRESS, EMERGENCY TELEPHONE NUMBER, AND DATE PREPARED.
- B) HAZARDOUS INGREDIENTS: HAZARDOUS COMPONENTS, CHEMICAL ID, AND COMMON NAMES. WORKER EXPOSURE LIMITS SUCH THE OSHA PEL AND ACGIH TLV AND OTHER RECOMMENDED LIMITS ARE ALSO INCLUDED IN THIS SECTION.
- C) PHYSICAL/CHEMICAL CHARACTERISTICS: ITEMS SUCH AS BOILING POINT, VAPOR PRESSURE, VAPOR DENSITY, MELTING POINT, EVAPORATION RATE, WATER SOLUBILITY, APPEARANCE, AND ODOR UNDER NORMAL CONDITIONS.
- D) PHYSICAL HAZARDS: SUCH AS FIRE, EXPLOSION, WAYS TO HANDLE THOSE HAZARDS, APPROPRIATE FIRE FIGHTING EQUIPMENT, ETC.
- E) REACTIVITY: THIS TELLS YOU WHETHER THE SUBSTANCE IS STABLE. THIS TELLS YOU WHICH SUBSTANCE AND SITUATIONS TO KEEP IT AWAY FROMSO IT WON'T REACT.
- F) HEALTH HAZARDS: HOW THE CHEMICAL CAN ENTER THE BODY, ALL POSSIBLE HEALTH HAZARDS THAT COULD COME FROM EXPOSURE, SIGNS AND SYMPTOMS OF EXPOSURE, AND EXISTING MEDICAL CONDITIONS THAT

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

COULD BE AGGRAVATED BY EXPOSURE. THIS AREA ALSO COVERS EMERGENCY AND FIRST AID PROCEDURES IF AN ACCIDENT DOES HAPPEN.

- G) PRECAUTIONS FOR SAFE HANDLING AND USE: THIS SECTION TELLS YOU WHAT TO DO IF A SUBSTANCE SPILLS OR LEAKS, HOW TO DISPOSE OF THE SUBSTANCE, EQUIPMENT AND PROCEDURES NEEDED FOR CLEANING UP SPILLS AND LEAKS, AND HOW TO HANDLE THE SUBSTANCE AND HOW TO STORE IT.

PAGE 4

0F 12

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16

TITLE: N-240 HAZARDOUS MATERIALS

- H) CONTROL MEASURES: THIS SECTION TELLS YOU HOW TO REDUCE HARMFUL EXPOSURE. IT DEALS WITH WHAT TYPE OF RESPIRATOR, GLOVES, EYE SHIELDS, PROTECTIVE CLOTHING, AND VENTILATION TO USE WHEN HANDLING THAT PARTICULAR CHEMICAL. ALSO, SPECIAL HYGIENE PRACTICES THAT SHOULD BE FOLLOWED WILL BE INCLUDED HERE.

IT MUST BE NOTED THAT NOT ALL INFORMATION WILL BE ON ALL MSDS'S. SOME INFORMATION DOES NOT PERTAIN TO CERTAIN CHEMICALS. WHEN MANUFACTURERS OR SUPPLIERS USE A STANDARD FORMAT SHEET, THOSE AREAS WILL USUALLY SAY "N/A". IT IS REQUIRED, HOWEVER, THAT ALL PERTINENT INFORMATION BE DISCLOSED ON EACH CHEMICAL. THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) HAS ISSUED A HAZARD COMMUNICATION STANDARD THAT SAYS ALL EMPLOYEES HAVE A "RIGHT TO KNOW" WHAT HAZARDS THEY FACE ON THE JOB AND HOW TO PROTECT THEMSELVES AGAINST THOSE HAZARDS.

IN ADDITION, ALL HAZARDOUS CHEMICALS WILL BE IDENTIFIED USING THE CRITERIA DEFINED BY THE RESOURCE CONSERVATION AND RECOVERY ACT OF 1976 (RCRA), SUBTITLE C, HAZARDOUS WASTE REGULATIONS, 40CFR, PART 261. A BRIEF SUMMARY OF THIS IDENTIFICATION CRITERIA IS AS FOLLOWS:

1) CHEMICAL CHARACTERISTICS:

A) IGNITABLE (FLAMMABLE). EXAMPLES: XYLENE, BENZENE, ETHYL ETHER, ACETONE, AND METHANOL.

B) CORROSIVE (PH 2.0 OR PH 12.5). EXAMPLES: SODIUM HYDROXIDE, HYDROCHLORIC ACID, SULFURIC ACID.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- C) REACTIVITY (UNSTABLE AT NORMAL TEMPERATURES AND PRESSURES, OR MAY RELEASE EXPLOSIVE VAPORS).
 - D) TOXICITY (TOXIC DUE TO CONTAMINATED HEAVY METALS OR SPECIFIC CHLORINATED ORGANICS).
- 2) ACUTELY HAZARDOUS CHEMICAL WASTES: EXAMPLES: ARSENATE AND ARSENIC CONTAINING COMPOUNDS, CYANIDE CONTAINING COMPOUNDS, WARFARIN, PARATHION, SODIUM AZIDE.
- 3) COMMERCIAL CHEMICAL PRODUCTS AND MANUFACTURING CHEMICAL INTERMEDIATES: EXAMPLES: CARBON TETRACHLORIDE, CHLORDANE, CHLOROFORM, PYRIDINE, TOLUENE.

SECTION: N SAFETY

PAGE 5 OF 12
DATE: 11/97, 7/03
REVIEWED: 3/12, 5/16

TITLE: **N-240 HAZARDOUS MATERIALS**

- 4) TOXIC WASTE: EXAMPLES: PHENOL, RESERPINE PCB'S.
- 3) STORAGE:
 - A) MATERIALS WHICH IGNITE EASILY UNDER NORMAL CONDITIONS (FLAMMABLES) ARE CONSIDERED FIRE HAZARDOUS AND WILL BE STORED IN A COOL, DRY, WELL VENTILATED STORAGE SPACE. THESE MATERIALS WILL BE KEPT WELL AWAY FROM SOURCES OF HEAT, FIRE, OR FLAME.
 - B) HIGHLY FLAMMABLE MATERIALS WILL BE KEPT IN AN AREA SEPARATE FROM OXIDIZING AGENTS (MATERIALS SUSCEPTIBLE TO SPONTANEOUS COMBUSTION OR HEATING, EXPLOSIVES, ETC).
 - C) THE STORAGE AREA FOR FLAMMABLES WILL BE SUPPLIED WITH FIRE FIGHTING EQUIPMENT, EITHER AUTOMATIC OR MANUAL. THERE WILL BE "NO SMOKING" SIGNS POSTED IN AND AROUND THE STORAGE AREA.
 - D) OXIDIZERS WILL NOT BE STORED CLOSE TO LIQUIDS OF LOW FLASH POINT.
 - E) ACIDS AND ACID FUME SENSITIVE MATERIALS WILL BE STORED IN A COOL, DRY, WELL VENTILATED AREA, PREFERABLY WOODEN.
 - F) MATERIALS WHICH ARE TOXIC AS STORED, OR CAN DECOMPOSE INTO TOXIC

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

COMPONENTS WILL BE KEPT FROM CONTACT WITH HEAT, MOISTURE,
ACIDS, OR ACID FUMES.

- G) CORROSIVE MATERIALS WILL BE STORED IN A COOL, WELL VENTILATED AREA, BUT WILL BE KEPT ABOVE THE FREEZING POINT. THE CONTAINERS WILL BE INSPECTED AT REGULAR INTERVALS TO ENSURE THAT THEY ARE LABELED, INTACT, AND KEPT CLOSED.
- H) CORROSIVES WILL BE ISOLATED FROM OTHER MATERIALS.
- I) PROTECTIVE CLOTHING AND EQUIPMENT WILL BE AVAILABLE FOR USE WHEN HANDLING THESE MATERIALS.

PAGE 6 OF 12

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED: 3/12, 5/16

TITLE: **N-240 HAZARDOUS MATERIALS**

- 4) DISPOSAL:
 - A) DISPOSAL OF SMALL AMOUNTS OF LIQUID CHEMICAL WASTES (60CC OR 2 OZ) MAY BE DISPOSED OF BY DILUTING 1 PART OF THE CHEMICAL WITH 100 PARTS OF WATER AND FLUSHED DOWN THE SEWER SYSTEM. THESE AMOUNTS SHOULD BE DILUTED AND FLUSHED DOWN THE SEWER AT VARYING TIMES DURING THE DAY, AND APPROXIMATED ACCORDING TO THE QUALITY OF CHEMICALS NEEDING DILUTION.
 - B) IN DILUTING CHEMICALS FOR FLUSHING DOWN THE SEWER SYSTEM, ALWAYS ADD THE 1 PART CHEMICAL TO THE 100 PARTS WATER. NEVER ADD WATER TO THE CHEMICAL AS THIS CAN CAUSE THE CHEMICAL TO SPLASH OUT OF THE CONTAINER.
 - C) WEAR RUBBER GLOVES, A MASK, AND/OR SAFETY EQUIPMENT AS REQUIRED WHEN PREPARING LIQUID CHEMICALS FOR DISPOSAL.
 - D) NO EMPTY DRUMS OR BUCKETS, OR ANY OTHER CONTAINERS THAT HAVE HELD TOXIC OR CORROSIVE CHEMICALS WILL EVER BE REUSED FOR ANYTHING. THESE CONTAINERS WILL BE DISPOSED OF AS FOLLOWS:

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- 1) WHILE WEARING PROTECTIVE GARB, WASH THE CONTAINER WITH HOT WATER AND SODA ASH OR A 5% CAUSTIC SOLUTION;
 - 2) FLUSH THE CONTAINER AND WASH TWICE MORE;
 - 3) PERFORATE TOP SIDES, AND BOTTOM OF THE CONTAINER TO PREVENT ITS BEING USED.
- E) THE ADMINISTRATOR OF THE CENTER IS RESPONSIBLE FOR ENSURING THAT PROPER PERMITS ARE OBTAINED FOR DISPOSAL OF ALL HAZARDOUS CHEMICAL WASTES GENERATED AT THE FACILITY.
- F) A CERTIFICATE OF DISPOSAL WILL BE OBTAINED FROM THE RECEIVER FOR ALL HAZARDOUS CHEMICALS DISPOSED OF OFF-SITE.

PAGE 7

OF 12

SECTION: N SAFETY

DATE: 11/97, 7/03
REVIEWED: 3/12, 5/16

TITLE: N-240 HAZARDOUS MATERIALS

WILDCREEK SURGERY CENTER WILL MAINTAIN AN UP TO DATE PROGRAM FOR THE PURPOSE OF COMMUNICATING TO EMPLOYEES ON HAZARDOUS CHEMICALS IN THE WORK PLACE.

RECORD KEEPING:

- 1) MATERIAL SAFETY DATA SHEETS:
THESE WILL BE KEPT UP TO DATE WITH ALL CURRENT AND ANY NEW CHEMICALS IN THE CENTER.
- 2) EMPLOYEE SIGN OFF SHEETS:
WHEN EMPLOYEES ATTEND THE HAZARDOUS COMMUNICATIONS PROGRAM AS PART OF THEIR ORIENTATION, THEY WILL SIGN AND DATE A FORM ACKNOWLEDGING THIS.
- 3) RESPONSIBILITIES:

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

THE CENTER'S NURSING MANAGER WILL BE RESPONSIBLE FOR ASSURING THAT ALL EMPLOYEES RECEIVE THE HAZARDOUS MATERIAL INFORMATION. THE OSHA PROGRAM COORDINATOR WILL OVERSEE AND MANAGE THE PROGRAM.

THE NURSING MANAGER OF WILDCREEK SURGERY CENTER WILL BE RESPONSIBLE FOR ALL HAZARDS, RECALLS, AND ALERTS. THIS PERSON WILL COLLECT AND REVIEW ALL DATA CONCERNING DEFECTIVE EQUIPMENT, PRODUCTS AND SUPPLIES WHICH MAY EFFECT THE GENERAL SAFETY OR PRESENT A RISK TO PATIENT CARE, VISITORS, OR CENTER STAFF.

PROCEDURE: 1) THE NURSE MANAGER WILL:

A) REVIEW ALL DATA COLLECTED FROM ALL SOURCES CONCERNING RECALLS OR PRODUCTS, OR SUPPLIES. ALERTS OF DEFECTIVE OR HAZARDOUS EQUIPMENT,

B) INFORM THE CENTER'S ADMINISTRATOR AND MEDICAL DIRECTOR.

C) DISSEMINATE HAZARDOUS RECALL OR ALERT INFORMATION TO APPROPRIATE STAFF MEMBERS INVOLVED IN THE UTILIZATION OF THE POTENTIAL HAZARDOUS EQUIPMENT, PRODUCTS, OR SUPPLIES.

PAGE 8 OF 12

SECTION: N SAFETY

DATE: 11/97, 7/03
REVIEWED: 3/12, 5/16

TITLE: **N-240 HAZARDOUS MATERIALS**

D) COLLECT, COORDINATE, AND EVALUATE INFORMATION RETURNED FROM THE INVOLVED AREAS TO ASSURE ANY ACTION REQUIRED HAS BEEN ADDRESSED AND HANDLED TO MINIMIZE RISK ASSOCIATED WITH THE ITEM IN QUESTION.

E) MONITOR ALL OUTSTANDING RECALLS TO ASSURE THAT ALL ISSUES OR POTENTIAL PRODUCT LIABILITIES HAVE BEEN RESOLVED TO COMPLETION.

F) MAINTAIN SUPPORTING DOCUMENTATION WITHIN THE CENTER.

G) REPORT RESULTS INCLUDING ANY ACTIONS TAKEN TO THE QAPI ASSURANCE COMMITTEE.

H) TAKE IMMEDIATE ACTION AS NECESSARY TO PROVIDE THE PROPER PROTECTION OF ALL PATIENTS, VISITORS, AND STAFF MEMBERS.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

I) CALL IN OTHER PERSONNEL TO ASSIST IN FINDING RESOLUTIONS TO IDENTIFIED ISSUES AS NECESSARY.

WILDCREEK SURGERY CENTER WILL COMPLY WITH ALL LOCAL, STATE, AND FEDERAL LAWS, RULES, AND REGULATIONS GOVERNING THE HANDLING AND DISPOSAL OF CONTAMINATED MEDICAL WASTE. THE CENTER WILL PROTECT ALL EMPLOYEES, VISITORS, AND STAFF MEMBERS FROM POSSIBLE EXPOSURE TO INFECTIOUS DISEASES THROUGH A WASTE MANAGEMENT PROGRAM.

IN ADDITION, THE CENTER WILL PROTECT THE PUBLIC AND THE ENVIRONMENT IN GENERAL BY CONTAINING ALL CONTAMINATED WASTES PRIOR TO THEIR DISPOSAL SO AS NOT TO CAUSE INFECTIOUS DISEASE TO BE SPREAD. THESE CONTAMINATED WASTES WILL BE CONTAINED AND DISPOSED OF IN A SAFE AND APPROVED MANNER.

PROCEDURE:

DEFINITION-INFECTIOUS MEDICAL WASTE:

BIOHAZARDOUS WASTE IS ANY SOLID OR LIQUID WASTE WHICH MAY PRESENT A THREAT OF INFECTION TO HUMANS. THE REQUIREMENTS FOR INDUCTION OF DISEASE IS THE PRESENCE OF

A PATHOGEN WITH SUFFICIENT VIRULENCE AND IN A QUANTITY SUBSTANTIAL ENOUGH SO THAT EXPOSURE TO THE WASTE BY A SUSCEPTIBLE HOST OR ORGANISM COULD RESULT IN AN INFECTIOUS DISEASE.

SECTION: N SAFETY

PAGE 9 OF 12
DATE: 11/97, 7/03
REVIEWED: 3/12, 5/16

TITLE: **N-240 HAZARDOUS MATERIALS**

IDENTIFICATION OF MEDICAL WASTE:

- ISOLATION WASTE FROM PATIENTS WITH INFECTIOUS DISEASE
- CULTURES AND STOCKS OF INFECTIOUS AGENTS AND ASSOCIATED BIOLOGICALS
- HUMAN BLOOD AND BLOOD PRODUCTS; USED, ABSORBENT MATERIALS SUCH AS BANDAGES, SPONGES, AND GAUZE SUPERSATURATED WITH BLOOD OR BODY FLUIDS HAVING THE POTENTIAL TO DRIP OR SPLASH
- PATHOLOGICAL WASTE; TISSUES, ORGANS, OR BODY PARTS

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- CONTAMINATED SHARPS; HYPODERMIC NEEDLES, SYRINGES, PIPETTES, BROKEN GLASS, SCALPEL BLADES, SUTURING NEEDLES, TROCHARS, ETC.

MEDICAL WASTE MANAGEMENT:

- 1) THE NURSE MANAGER WILL BE RESPONSIBLE FOR THE DEVELOPMENT AND MAINTENANCE OF A MEDICAL WASTE MANAGEMENT PROGRAM.
- 2) THE WASTE MANAGEMENT PROGRAM WILL INCLUDE:
 - A) EMPLOYEE TRAINING IN MEDICAL WASTE HANDLING
 - B) MONITORING OF PROPER PACKAGING AND LABELING
 - C) FOLLOW-THROUGH ON TRACKING PROCEDURES
 - D) CONTINGENCY/EMERGENCY PLAN
- 3) ALL POTENTIALLY INFECTIOUS MEDICAL WASTE WILL BE SEPARATED FROM GENERAL FACILITY GARBAGE AT ITS POINT OF ORIGIN.
- 4) ALL POTENTIALLY INFECTIOUS MEDICAL WASTE WILL BE PLACED IN BOXES LABELED "BIOHAZARD WASTE" THAT CONSPICUOUSLY DISPLAYED THE BIOHAZARD SYMBOL. THESE BOXES WILL BE LINED WITH TWO (2) RED PLASTIC BAGS THAT ARE IMPERVIOUS, AND TEAR RESISTANT.
- 5) EACH HAZARDOUS WASTE BOX WILL NOT EXCEED A FIFTY (50) POUND MAXIMUM WEIGHT LIMIT.

PAGE 10 OF 12

SECTION: N SAFETY

DATE: 11/97, 7/03
REVIEWED: 3/12, 5/16

TITLE: **N-240 HAZARDOUS MATERIALS**

- 6) ALL FLUIDS PLACED IN THE HAZARDOUS WASTE BOX WILL BE CONTAINED; CAPS WILL BE PLACED SECURELY ON ALL PORTS OF SUCTION CONTAINERS. BULK BLOOD, SUCTIONED FLUIDS, EXCRETIONS, AND SECRETIONS MAY BE CAREFULLY POURED DOWN A DRAIN CONNECTED TO SANITARY SEWER.
- 7) ALL SHARPS WILL FIRST BE PLACED IN A PUNCTURE PROOF SHARPS CONTAINER. WHEN FILLED, THE SHARPS CONTAINER WILL BE SECURELY CLOSED AND DISPOSED OF IN THE HAZARDOUS WASTE BOX.
- 8) FILLED HAZARDOUS WASTE BOXES WILL BE SECURED BY FOLDING THE INNER RED BAG OVER THE CONTENTS, THEN TWISTING THE OUTER RED BAG, CLOSED AND SECURED WITH A TIE. THE LID MUST BE ABLE TO FIT SNUGLY ON TO THE BOX; BOXES WILL NOT BE OVERFILLED.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

- 9) A SECURED BIO-HAZARDOUS WASTE BOX WILL BE KEPT IN LOCKED STORAGE IN THE SOILED WORK AREA UNTIL PICKED UP. THIS AREA HAS BEEN DESIGNATED FOR CONTAMINATED WASTE CONTAINERS, AND HAS RESTRICTED ACCESS BY UNAUTHORIZED PERSONS.
- 10) PICK-UP WILL BE ARRANGED ON A AS NEEDED BASIS, OFTEN ENOUGH TO PREVENT INFESTATION.
- 11) IN THE EVENT OF LEAKAGE OR ACCIDENTAL SPILL OF A HAZARDOUS WASTE BOX, PROTECTIVE ATTIRE WILL BE WORN AND THE CONTENTS WILL BE PLACED IN AN INTACT HAZARDOUS WASTE BOX. SPILLS WILL BE CLEANED UP USING A GERMICIDAL AGENT AND DISPOSABLE TOWELS. ALL MATERIALS USED IN CLEANING THE SPILL WILL THEN BE DISPOSED OF IN A HAZARDOUS WASTE BOX; SATURATED OR DRIPPING MATERIALS WILL FIRST BE PLACED IN A PLASTIC BAG.
- 12) TRANSPORTATION OF THE FILLED HAZARDOUS WASTE BOXES OFF THE PREMISES WILL BE BY ENCLOSED, LEAK PROOF TRUCKS.
- 13) DOCUMENTATION OF PICK-UP WILL BE MAINTAINED BY THE CENTER; DOCUMENTATION OF APPROPRIATE DISPOSAL WILL BE MAINTAINED BY THE RECEIVING SERVICE AS WELL AS TRACKING OF CENTER VOLUME.
- 14) WASTE MANAGEMENT IS A STATE APPROVED BIO-HAZARDOUS WASTE DISPOSAL SERVICE, AND WILL BE UTILIZED FOR THE COLLECTION OF WILDCREEK SURGERY CENTER'S BIO-HAZARDOUS WASTE.

PAGE 11 OF 12

SECTION: N SAFETY

DATE: 11/97, 7/03
REVIEWED: 3/12/ 5/16

TITLE: **N-240 HAZARDOUS MATERIALS**

- 15) POLICIES AND PROCEDURES RELATING TO THE OPERATION OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT SYSTEM WILL BE REVIEWED ANNUALLY.
- 16) THE QUALITY ASSURANCE/RISK MANAGEMENT COMMITTEE WILL BE RESPONSIBLE FOR TRACKING THE MANAGEMENT OF HAZARDOUS WASTE, SECURING REGULATIONS, AND MAINTAINING COMMUNICATION FOR OPERATION WITH WASTE MANAGEMENT.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

PAGE 12 OF 12

SECTION: N SAFETY

DATE: 11/97, 7/03

REVIEWED:

3/12, 5/16

TITLE: N-250 EMERGENCY GENERATOR

POLICY: WILDcREEK Surgery Center will maintain an
Emergency

Generator to provide consistent electrical power
to all necessary equipment in the event of an
electrical

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

power FAILURE. THE Emergency Generator is located outside the building in the northwest corner of the Center. The Center will maintain a service contract for maintenance and repair with a local outside agency. The Center will DO WEEKLY GENERATOR CHECKS AND A MONTHLY 30 MINUTE LOADED RUN WHICH WILL BE DOCUMENTED IN THE GENERATOR LOG BOOK.

PROCEDURE:

- 1) The Generator Log Book will be kept in the NURSE MANAGER'S office.
- 2) THE ADMINISTRATOR WILL monitor TESTING OF the Emergency Generator, maintain the log, and ASSURE PERIODIC TESTING IS DONE BY OUTSIDE CONTRACTOR PER SERVICE AGREEMENT.
- 3) Fuel for the Generator is natural gas
- 4) Problems encountered, maintenance or repairs needed, or other areas of concern noted will be reported to, and taken care of by the CENTER'S ADMINISTRATOR, BUSINESS OFFICE OR NURSE MANAGER.
- 5) Maintenance and repairs will be scheduled and conducted on a timely basis.

SECTION: N SAFETY
7/03, 5/16

DATE: 11/97,

REVIEWED: 3/12

TITLE: N-260 WHEELCHAIR AND STRETCHER SAFETY

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

POLICY: WILDCREEK SURGERY CENTER WILL ENSURE THAT SAFETY IS A PRIORITY IN THE CARE OF PATIENTS BEING TRANSPORTED BY WHEELCHAIR OR STRETCHER THROUGHOUT OUR FACILITY

PROCEDURE: WHEELCHAIR SAFETY:

1. LEG AND FOOTRESTS SHALL BE UTILIZED AS INDICATED BY THE PATIENTS CONDITION.

2. URINARY DRAINAGE BAGS SHALL BE HUNG TO FACILITATE GRAVITY FLOW AND TO AVOID ENTANGLEMENT IN THE WHEELS OF THE CHAIR.

3. PATIENTS WITH IV'S, OXYGEN THERAPY, TUBES, EQUIPMENT, ETC., SHALL BE ASSESSED BY THE NURSING PERSONNEL BEFORE TRANSPORT.

4. UPON TRANSFER OF PATIENTS INTO AND OUT OF A WHEELCHAIR, THE WHEELS WILL BE LOCKED.

5. WHEN A PATIENT IS STATIONARY IN A WHEELCHAIR, THE WHEELS WILL BE LOCKED.

6. WHEN A WHEELCHAIR, OR ANY PART OF IT IS FOUND TO BE WORN OR DEFECTIVE, THE DEPARTMENT MANAGER WILL BE NOTIFIED AND THE WHEELCHAIR WILL BE TAKEN OUT OF SERVICE AND REPAIRED.

7. WHEELCHAIRS SHALL BE PULLED RATHER THAN PUSHED OVER DOORWAY ELEVATION CHANGES AND EXTREMITIES SHALL BE POSITIONED TO PREVENT INJURY UPON

TRANSPORT.

PROCEDURE: STRETCHER SAFETY

1. UPON TRANSFER FROM THE OPERATING ROOM TABLE TO THE STRETCHER, OR OPPOSITE, THE LEVEL SHALL BE EQUAL.

2. THE WHEELS OF THE STRETCHER AND OPERATING ROOM TABLE SHALL BE LOCKED BEFORE TRANSFER

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

3. ALL IV BAGS AND TUBING, OXYGEN TUBING, DRAINAGE TUBING, DEVICES, ETC., ATTACHED TO THE PATIENT SHALL BE ARRANGED AND SECURED BEFORE TRANSPORT.

4. TRANSPORT PATIENTS FEET FIRST ON STRETCHERS WITH THE SIDE RAILS UP.

5. IN THE EVENT THAT ONLY ONE PERSON IS PERFORMING THE TRANSPORT OF A STRETCHER THAT PERSON SHALL BE AT THE HEAD OF THE STRETCHER.

6. PROTECT PATIENTS EXTREMITIES UPON TRANSPORTING THROUGH DOORWAYS.

SECTION: N SAFETY
7/03, 5/16

DATE: 11/97,

REVIEWED: 3/12

TITLE: N-270 LIFTING AND MOVING SAFETY

POLICY: WILDCREEK SURGERY CENTER WILL ENSURE THE MAINTENANCE OF EMPLOYEE AND PATIENT SAFETY AS PRIORITIES IN THE WORK PLACE.

PROCEDURE: THE CENTERS WORK ENVIRONMENT CONTAINS TASKS THAT REQUIRE HEAVY LIFTING AND MOVING OF PATIENTS, EQUIPMENT, AND SUPPLIES. BACK INJURY AND HERNIAS ARE THE MOST COMMON RESULTS OF IMPROPER BODY MECHANICS AND LIFTING TECHNIQUES. ALL EMPLOYEES WILL BE RESPONSIBLE FOR KNOWING AND UTILIZING PROPER BODY MECHANICS TO PREVENT AND AVOID SUCH INJURIES.

LIFTING AND MOVING GUIDELINES:

1. UTILIZE MECHANICAL DEVICES FOR LIFTING PATIENTS OR HEAVY OBJECTS WHEN APPROPRIATE
2. UTILIZE APPROPRIATE CARTS FOR TRANSPORTING HEAVY OBJECTS
3. ENLIST THE HELP OF A CO-WORKER WHEN LIFTING HEAVY OBJECTS OR PATIENTS
4. CARRY THE LOAD IN A MANNER THAT PERMITS YOU TO SEE WHERE YOU ARE GOING

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

5. CARRY THE LOAD THE SHORTEST POSSIBLE DISTANCE
6. KEEP THE BACK STRAIGHT
7. THE LOAD SHALL BE BALANCED AND CARRIED WITH A FULL PALM GRIP
8. THE LOAD SHALL BE CARRIED CLOSE TO THE BODY
9. DO NOT ATTEMPT TO CARRY A LOAD THAT IS TOO HEAVY OR BULKY
10. UTILIZE LEG AND ARM MUSCLES TO DO THE LIFTING, NOT YOUR BACK
11. MAINTAIN A WIDE LEG STANCE WHEN LIFTING
12. A cd IN-SERVICE EDUCATION CONCERNING PROPER BODY MECHANICS IS AVAILABLE.

SECTION: N SAFETY

DATE: 04/10
REVIEWED: 3/12, 5/16

TITLE: **N-280 FIRE WATCH**

PURPOSE: To establish a plan of action should the fire alarm system **or** sprinkler system be out of service for more than 4 hours in a 24-hour period. (Procedures must address both the fire alarm and sprinkler systems.)

ACCESS: Available in writing at staff stations and comprehended by training of all facility staff.

STAFF: Facility staff trained in Rescue, Alarm, Contain, and Extinguish/ Evacuate (RACE) and the implementation of a facility-wide fire watch.

DOCUMENTATION: Each tour is recorded with findings noting date time, and staff initials. A fire watch tour is a periodic walking tour of the entire facility by one or more assigned and trained staff. This **MUST BE** staffs **ONLY** responsibility during the Fire Watch. The tour monitors the facility through direct observation of all rooms for possible signs of fire.

OCCURANCES: Fire alarm system outages or sprinkler system outages can occur during construction, maintenance, renovation, electrical storms or other unplanned events which eliminate part or all of the fire alarm system. Sprinkler systems may also be made inoperable by a variety of planned and unplanned events.

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

PROCEDURE:

1. Contact the facility administrator, nurse director and business office manager when any problems are encountered with the fire alarm system or sprinkler system.
(Action: staff)
2. Contact the fire alarm or sprinkler contractor at (775) 823-7300 should maintenance be unable to correct the problem.
(Action: nurse director or business manager).
3. Contact the facility alarm company at (888) 289-2647 should maintenance be unable to correct the problem.
(Action: nurse director or business manager).
4. Fire alarm or sprinkler contractor shall be on site or on contract until system is repaired, replaced or reinitialized and working.
5. Notify the fire department at (775) 353-2255 that the sprinkler system or fire alarm system is not working correctly.
(Action: administrator/nurse director/ business manager).
6. If the sprinkler or fire alarm system is inoperable for a time period of more than 4 hours in a 24 hour period, notify the Nevada Department of Health District Office. They can be contacted at (775) 688-2811.
(Action: administrator/ nurse director/business manager).
7. Fire watch procedure shall designate facility tours designating floor and building identifier.
(Action: Facility Administrator/ nurse director)
8. Fire watch tours shall occur at ¼ hour intervals, 24 hours a day.
(Action: Facility Administrator/ nurse director)

notice

the building fire alarm system is
inoperative

from _____ to _____

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

EVERY EFFORT IS BEING MADE TO COMPLETE THE REPAIRS AS SOON AS POSSIBLE.

IMMEDIATELY CONTACT 775-674-1100 IF YOU DETECT ANY OF THE FOLLOWING:

- *SEE OR SMELL, OR*
- *DETECT THE PRESENCE OF FIRE, OR*
- *SMELL NATURAL GAS, OR*
- *DETECT THE PRESENCE OF ANY OTHER CONDITION WHICH ENDANGERS THE LIFE OF BUILDING OCCUPANTS.*

FIRE WATCH LOG

<u>DATE</u>	<u>TIME</u>	<u>AREA COMPROMISED</u>	<u>INITIALS</u>

Patient Safety Plan

2019

Barton Health

Name Here, MSN, MBA, RN, PHN, CPPS
Director of Patient Safety

Executive Summary

The purpose of the Patient Safety Plan is to set the foundation for patient safety at Barton Health in accordance with state and regulatory requirements. The breadth of Patient Safety is vast and includes event reporting, review, follow up on errors and harm that impact or have the potential to impact patients, hazard mitigation through evidence-based tools, and reporting to internal committees and external agencies. The Patient Safety Plan addresses high reliability processes to correct opportunities for improvement and prevent identified hazards from recurrence. 2018 high priorities are reviewed which included: reducing falls across the organization, tubing connections, teamwork enhancement through TeamSTEPPS in the outpatient clinics, assessing communication in relation to patient hand-offs/hand overs, and clinical alarms. 2019 high priorities include medication safety, labor interruptions, tubing connections, teamwork enhancement through TeamSTEPPS, improving patient handover communication, clinical alarms, hospital survey on patient safety culture analysis, and Just Culture training. . The Patient Safety Plan grants authority for Patient Safety oversight across the organization to the Chief Medical Officer and the Director of Patient Safety. This plan is revised and updated annually or more often as needed.

Table of Contents

Executive Summary	2
Table of Contents	3
Section A: 2019 Patient Safety Plan	4
Purpose	5
Introduction	5
Scope of the Patient Safety Plan	6
Risk Assessment	6
Event Prioritization	6
Event Reporting	7
Regulatory Agency Reporting	7
Patient Safety Organization Reporting	12
Investigation: Root Cause Analysis and Process Improvements	12
Disclosure	13
Patient Safety Committee	13
Patient Safety Risk Reduction	14
Educational Enhancement Activities	15
Patient Safety Evaluation	15
Patient Safety Plan Approval, Revision and Review	15
Authority	15
Approval	15
Section B: 2018 Patient Safety Priority Evaluation	16
Section C: 2019 Patient Safety Priorities	18
References	20
Appendix A: 2019 Lake Tahoe Surgery Center Patient Safety Plan	22

Section A

2019 Patient Safety Plan

Purpose

Barton Health is committed to continuously improving patient safety and reducing health care errors. This Patient Safety Plan ensures that Barton Health implements and maintains a patient safety program in accordance with The Joint Commission standards, guidelines from the California Department of Public Health (CDPH), Nevada Revised Statutes (NRS), Patient Safety and Quality Improvement Act of 2005, and other regulatory agencies.

Introduction

The Patient Safety Plan supports and promotes the mission, vision, values, and strategic plan of Barton Health. This Plan implements continuous integration and coordination of patient safety activities for all medical staff, clinical departments, support service departments and service lines including trauma at Barton Health. A culture of safety inherently implies the continued attention, refinement and progression of the patient safety plan and program.

Barton Health's patient safety goal is to foster an environment and culture where patients, families, staff and leaders within the organization identify and manage actual and potential risks to patient safety thereby resulting in zero harm. All patients and staff are strongly encouraged and supported with multiple avenues/programs to speak up when safety concerns are identified. As an organization, Barton Health has the obligation to listen and respond to these concerns.

The Patient Safety Plan is designed to reduce patient safety errors and improve patient care delivery processes by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach centers on the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reductions in health related errors including near miss and good catch events; and integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions, and services. Patient safety is emphasized in areas such as patient's rights, patient and family education, continuity of care, risk reduction, and managing performance improvement.

Each employee performs a critical role in patient safety and thus, Barton Health's journey to becoming a high reliability organization. All Barton Health team members are focused on providing consistently exceptional care through an environment that supports teamwork, collaboration and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and safety while setting expectations for those who work in the organization. Leadership evaluates the culture of safety on a regular basis.

The Chief Medical Officer and Director of Patient Safety, provide oversight to the integrated patient safety program. These individuals ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.

The Director of Patient Safety and Patient Safety Department have the authority to intervene in any clinical or non-clinical activity which poses an actual or potential negative outcome to a patient's well-being. The Patient Safety Department provides leadership in the creation, initiation and evaluation of corrective action measures for event resolution.

The Governing Body, Board Quality Committee, and Patient Safety Committee, described below, are committed to patient safety. These bodies shall assure an environment that encourages error identification, remediation, non-punitive reporting, and prevention through education, system redesign, or process improvement for any potential or actual adverse event.

In accordance with The Joint Commission's Accreditation Participation Requirements, APR.09.02.01, this plan implies Barton Health shall:

- Educate its staff, medical staff, and other individuals who provide care, treatment, and services that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission.
- Inform its staff and medical staff that Barton Health will take no disciplinary or punitive action because an employee, physician, or other individual who provides care, treatment, and services reports safety or quality of care concerns to The Joint Commission.
- Take no disciplinary or punitive action against employees, physicians, or other individuals who provide care, treatment, and services when they report safety or quality of care concerns to The Joint Commission.

Any employee or medical staff member may contact The Joint Commission if they have a safety or quality of care concern that is not being addressed by Barton Health. All employees or medical staff members are strongly encouraged to bring any safety or quality of care concerns to the Chief Medical Officer, Director of Patient Safety, Patient Safety Team members, or Director of Quality without fear of punitive or disciplinary action.

In addition, patients are provided information in the patient handbook regarding their right to contact and report a complaint to The Joint Commission.

Scope of the Patient Safety Plan

The Joint Commission, CDPH, NRS, Centers for Medicare and Medicaid Services (CMS) and other regulatory agencies provide the defining framework for patient safety events. The Patient Safety Department is informed of safety event information and hazardous conditions from team members, volunteers, and medical staff practitioners across the organization through completion of event reports and verbal or written communication. This information includes actual or potential (near miss/good catch) occurrences involving inpatients, outpatients, volunteers, employees, physicians, allied healthcare providers, vendors, and visitors.

Risk Assessment

Proactive assessment of high risk activities and hazardous conditions are identified through event reporting, failure mode and effect analysis (FMEA), data collection, audits (tracers), and utilization. In addition, risk reduction strategies are built into the continual process improvement system. Such strategies are obtained from available information regarding sentinel events known to occur in healthcare organizations that provide similar care and services as well as knowledge based information including content from state patient safety organizations as well as other state, national, and international professional organizations.

Event Prioritization

Opportunities for improving patient safety issues are prioritized according to level of severity, frequency of the occurrence, potential for harm to the patient, employee or visitor involvement, and potential for liability. Ongoing review of information is performed to direct administrative and medical staffs' attention to areas of clinical care representing significant sources of actual or potential risk.

Types of medical / health care errors include, but are not limited to:

- **Adverse Event:** Per The Joint Commission, an adverse event is a patient safety event that resulted in harm to a patient. It is also defined as an unexpected occurrence meeting any of the Adverse Event criteria as designated by CDPH.
- **Error:** An unintended omission or commission of an act, or an act that does not achieve its intended outcome.
- **Good Catch/Close Call/Near Miss:** Any patient safety event that did not reach the patient.
- **No-Harm Event:** A patient safety event that reached the patient but did not cause harm.

- **Hazardous Condition:** Any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which increases the probability of an adverse event.
- **Never Event/Serious Reportable Event (SRE):** An event or situation that should never occur in a healthcare facility.
- **Sentinel Event:** A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm (Refer to *Sentinel Event* section below) and is reported to The Joint Commission. For Lake Tahoe Surgery Center, located in Nevada, a sentinel event is defined in NRS 439.830 by the National Quality Forum. (Refer to Appendix A).
- **Healthcare Associated Infection (HAI):** A localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) as defined by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) in addition to monthly submission of all surgical site infections associated with different procedures performed at Barton Health. Potential HAIs are reviewed by the HAI Review Committee. Confirmed HAIs are reported to the Patient Safety Committee. HAIs are also reported to the Infection Control and Prevention Committee and Board Quality Committee.

Any patient safety event, incident, or condition that could have resulted or did result in harm to a patient shall be subject for review and further analysis.

Event Reporting

Identification and reporting of adverse events, including those that result from practitioner error are critical to Barton Health's efforts to continuously improve patient safety and reduce harm. To support and encourage this culture of safety, reporting of patient safety events or near misses is highly encouraged. Reporting of events is the responsibility of all employees, volunteers, practitioners, patients, visitors and guests. Events can be reported through many modalities including electronic, verbal, and written communication. Electronic event reporting is available on all Barton Health System computer terminals. An event is reported via the electronic event reporting system by the individual(s) involved with and most knowledgeable about the event. (Refer to Barton Health Organizational Event Reporting Policy.)

Events are reviewed on a daily basis. High severity events are reviewed promptly to ensure immediate action is taken as warranted.

Regulatory Agency Reporting

Barton Health informs accrediting and licensing bodies when errors and events fall within that agency's reporting requirements. Team members involved in sentinel or adverse events have access to support and are included whenever possible in the root cause analysis process to ensure the potential for recurrence is minimized.

Intensive assessment may be initiated when undesirable patterns or trends are identified or serious, adverse, or sentinel events occur. This includes those events identified as unusual occurrences within the California Code of Regulations section 76551. Sentinel Events reportable to The Joint Commission and Adverse Events reportable to CDPH are delineated below. (Refer to Appendix A for Nevada Sentinel Event reporting.)

Sentinel Event

Patient safety events are determined to fall into the category of a Sentinel Event as defined by The Joint Commission when any of the following occur:

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying

condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm*

Or

The event is one of the following (even if the outcome was not death, or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):

- Suicide of any patient receiving care, treatment and services in a staffed around the clock care setting or within 72 hours of discharge including from the hospital's emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including ED), leading to death, permanent harm, or severe temporary harm to the patient
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the organization
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while on site at the organization
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery after the completion of final skin closure
- Severe neonatal hyperbilirubinemia (bilirubin greater than 30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field or any delivery of radiotherapy to the wrong body region or greater than 25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care
- Any intrapartum (related to the birth process) maternal death
- Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm from the intrapartum through postpartum period (24 hours) requiring the transfusion of 4 or more units of packed red blood cells and/or admission to the ICU

*Severe temporary harm is critical, potentially life threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

It is Barton Health's policy to voluntarily report Sentinel Events to The Joint Commission within their required reporting timeframe (Refer to Barton Health Sentinel Event Policy).

Adverse Event

Barton Health shall report an adverse event as defined within Health and Safety Code §1279.1 (below) to CDPH no later than five calendar days after the event has been detected or, if the event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, no later than 24 hours after the adverse event has been detected. Events are investigated, mitigation actions initiated, and cooperation with CDPH occurs throughout the process. (Refer to Barton Health Adverse Event policy)

"Adverse event" includes *any* of the following:

1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.
6. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
9. An infant discharged to the wrong person.
10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.
11. A patient suicide or attempted suicide resulting in serious disability due to patient actions after admission, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.
12. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
13. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

17. A Stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
18. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.
19. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
21. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
22. A patient death associated with a fall while being cared for in a health facility.
23. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
25. The abduction of a patient of any age.
26. The sexual assault on a patient within or on the grounds of the facility.
27. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.
28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

Never Events/Serious Reportable Events

Barton Health reports Never Events/SREs to the appropriate agency based on the circumstances of the event and criteria met of the regulatory agencies (e.g., CDPH and/or The Joint Commission). Never Events/ SREs include:

1. Surgical or Invasive Procedure Events

- 1A. Surgery or other invasive procedure performed on the wrong site.
- 1B. Surgery or other invasive procedure performed on the wrong patient.
- 1C. Wrong surgical or other invasive procedure performed on a patient.
- 1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
- 1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient.

2. Product or Device Events

- 2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.
- 2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
- 2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.

3. Patient Protection Events

- 3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
- 3B. Patient death or serious injury associated with patient elopement (disappearance).
- 3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.

4. Care Management Events

- 4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
- 4B. Patient death or serious injury associated with unsafe administration of blood products.
- 4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in

a healthcare setting.

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting.

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting.

4G. Artificial insemination with the wrong donor sperm or wrong egg.

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

5. Environmental Events

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting.

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances.

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting.

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

6. Radiologic Events

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

7. Potential Criminal Events

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.

7B. Abduction of a patient/resident of any age.

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

Provider-Preventable Conditions

Federal law requires Provider-Preventable Conditions (PPCs) that occur during treatment of Medi-Cal and Medicaid patients be reported. These include both healthcare-acquired conditions (HCAC) and other provider-preventable conditions (OPPC). California HCACs and OPPCs are reported to the Department of Health Care Services after discovery and confirmation that the patient is a Medi-Cal beneficiary. Nevada HCACs are reported through the Nevada sentinel event registry.

HCACs are defined as:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
 - Diabetic ketoacidosis
 - Nonketotic hyperosmolar coma
 - Hypoglycemic coma
 - Secondary diabetes with ketoacidosis
 - Secondary diabetes with hyperosmolality

- Stage III and IV pressure ulcers
- Surgical site infection following:
 - Mediastinitis following coronary artery bypass graft (CABG)
 - Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery
 - Orthopedic procedures for spine, neck, shoulder, and elbow
 - Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection
- Deep vein thrombosis (DVT)/ pulmonary embolism (PE) excluding pregnant women and children under 21 years of age

OPPCs are also known as “never events” and Serious Reportable Events under Medicare. For Medi-Cal, OPPCs are defined as:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Providers must report these three OPPCs when these occur in any health care setting. “Invasive procedure” refers to a surgical procedure.

Patient Safety Organization Reporting

Barton Healthcare System is a member of the California Hospital Patient Safety Organization (CHPSO), which serves as its Patient Safety Organization. Patient Safety Work Product is submitted to CHPSO in accordance with the Patient Safety and Quality Improvement Act of 2005. (Refer to Patient Safety Evaluation System Policy for further details.)

Investigation: Root Cause Analysis and Process Improvements

In any event when an adverse/sentinel event or hazardous condition has occurred, the issue is revisited and the status mitigated through a risk reduction strategy using the Root Cause Analysis (RCA) process. Lesser events are managed through either an RCA or Process Improvement (PI). Reportable Adverse or Sentinel Events shall be subject to an immediate in-depth RCA.

RCAs shall be convened by the Director of Patient Safety or designee and includes team members either directly or indirectly involved in the event. Members from uninvolved departments may be invited to provide additional information. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting the RCA. The Root Cause Analysis and Action Plan Framework Table, introduced by the Joint Commission, contains 24 analysis questions that guide the organization through the steps in a root cause analysis. Not all the questions apply to all the events or cases. The 5 Whys technique is utilized to explore the cause and effect relationship underlay a problem. Root causes can be identified by asking “why” no less than five times. During the RCA, events are deconstructed in an effort to identify the key causes that may have contributed to the event. The deconstruction process leads to action items designed to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors. The Veterans Affairs National Center for Patient Safety Action Hierarchy is used to assure strong corrective action items are identified.

Process Improvement teams are formed when an issue affecting more than one service line is identified and a near miss may or may not be involved. There may be no adverse patient outcome in connection with the event, however, the potential for a patient event should the issue recur is likely. PIs may also result from discussions during RCAs where a system improvement process is identified as a result of a patient event. Team members convene and identify key factors involved in the process through deconstruction that may have contributed to the situation and create action items to mitigate the identified issues.

RCA and PI workgroups construct action items and assign them to appropriate individuals for completion. Providers and staff involvement is considered essential, since they are the team members on the front line with the most knowledge of the actual day-to-day workings of the processes. Individuals assigned action items are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

As a learning organization utilizing Just Culture, Barton Health focuses on systems and processes, not individuals, during RCA or PI event review.

Disclosure

Full disclosure of serious medical errors, reportable events and any unanticipated outcomes are communicated to patients/families by the practitioner with the assistance of the Risk Manager, Director of Patient Safety, Patient Safety Officer, Patient Safety Specialist RN, or designee as appropriate. (Refer to Barton Health Disclosure of Unanticipated Outcome Policy.)

Patient Safety Committee

The Patient Safety Committee is a multidisciplinary team focused on review and discussion of patient events resulting in a near-miss or an untoward outcome as well as process improvements for the purposes of improving patient safety and the quality of care delivered to Barton Health's patients.

The Patient Safety Committee is a standing committee of the Medical Staff. The committee's membership is delineated in Barton Health's Medical Staff Rules.

The Patient Safety Committee shall review and discuss Code Blues, hospital deaths, Rapid Response Team activations (including near codes), systems issues identified by peer review processes, HAIs, serious patient events, and reportable adverse and sentinel patient events. Adverse/sentinel patient events include unanticipated events that affect patient care or patient safety and encompass all service lines of care.

The Committee promotes the application of evidence-based methods in the resolution of patient safety events and reviews RCA and PI workgroup recommendations which ultimately minimize the recurrence of comparable patient events or near misses. Recommendations can be revised, added or deleted through this committee.

The Lake Tahoe Surgery Center Patient Safety Committee is a subcommittee of, and reports to, the Patient Safety Committee. Refer to Appendix A.

Department Directors or designees are active participants who complete assigned action items within an appropriate timeframe designated by the work group, Director of Patient Safety, Patient Safety Officer, Patient Safety Specialist RN, Chief Medical Officer, or Patient Safety Committee. Directors are responsible for implementing action items and reporting back to the Patient Safety Committee and/or the Patient Safety Department with status updates and upon completion of assigned action items. Directors are responsible to ensure continued compliance exists with their direct reports and implemented process changes are sustained.

Events and PIs shall be closed through the Patient Safety Committee when all assigned action items have been completed, any associated audits exhibit compliance, and all remaining concerns are addressed.

The Director of Patient Safety or designee shall report patient safety events and process improvements from the Patient Safety Committee to the Board Quality Committee. The Chief Medical Officer or designee shall report acute events and process improvements from the Patient Safety Committee to the Medical Executive Committee and Governing Board.

Patient Safety Risk Reduction

Several approaches are utilized at Barton Health to reduce the risk of a patient safety event. The Joint Commission's National Patient Safety Goals, National Healthcare Safety Network (NHSN), Institute for Healthcare Improvement (IHI), Agency for Healthcare Research and Quality (AHRQ), National Patient Safety Foundation, and California Hospital Patient Safety Organization (CHPSO) are some examples of utilized resources to prevent and reduce the likelihood of serious patient safety events. Sentinel Event Alerts released through The Joint Commission are also analyzed for compliance.

National Patient Safety Goals

Compliance with The Joint Commission's National Patient Safety Goals are monitored and evaluated on a continual basis through observational audits. Data analyses of these audits shall be reported to and reviewed by Board Quality Committee on a biannual basis. Measure of success for compliance on each standard's requirement is expected to be 100% (one hundred percent). Elements below 100% (one hundred percent) are addressed by the appropriate Department Director/Manager. The Director/Manager shall formulate an action plan with the goal of improving the affected element score within their department.

Patient Safety observational audits (tracers) are conducted on a routine basis. Immediate training is provided to staff when non-compliance with policy elements is observed. (Refer to Patient Safety Observational Tracer Policy.)

Sentinel Event Alerts

Sentinel Event Alerts, published through The Joint Commission, are communicated through the Patient Safety Committee. Compliance status and opportunities for improvement are addressed through workgroups consisting of affected Department Directors/Managers, Executive Team Members and others as appropriate to formulate risk reduction strategies and follow up through an action plan. Action items within the action plan are assigned to individuals who are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

Scientific Model Integration

The patient safety program has been developed with scientific knowledge in a foundational aspect including concepts from:

- Shewhart cycle or Model for Improvement (Plan, Do, Study, Act –PDSA)
- Failure Mode and Effects Analysis (FMEA)
- Re-engineering (Human factor re-engineering such as signage for High Alert Medications, Pop up alert in Pyxis medication dispensing system, Tall man lettering for look-alike sound alike drugs in medication usage process, etc.)
- Rapid Cycle Improvement (IHI Collaborative approach termed the 'Breakthrough Series', to bring about rapid cycle improvements. Fundamental to the collaborative approach is the acceptance of a model and establishment of infrastructure through which collaborating organizations can identify and prioritize aims for improvement and gain access to the methods, tools, materials etc.)
- RCA²: Improving Root Cause Analyses and Actions to Prevent Harm

- Process Improvement such as Lean and Six Sigma concepts
- Evidence-based practice and clinical practice guidelines

Educational Enhancement Activities

The Patient Safety Plan provides the opportunity to reduce patient safety events and hazardous conditions through education, proper and effective orientation, and annual training. Barton Health's clinical orientation program emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing patient safety training for Barton Health team members including practitioners is offered through various teaching strategies including, but not limited to, bulletin boards, online learning formats, skills labs, and didactic experiences. Program content may include education specific to patient safety related events or advancements in patient safety practice. As appropriate, this training incorporates methods of team training such as TeamSTEPPS by AHRQ to foster an interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and mechanisms to report patient safety concerns.

Patient Safety Evaluation

Annually, patient safety activities shall be reviewed and presented to the Patient Safety and Board Quality Committees.

Patient Safety Plan Approval, Revision, and Review

The Patient Safety Committee shall review and approve this plan at least once a year, but more often as necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices. The Board Quality Committee shall review and approve this plan at least annually.

Authority

The authority to implement the Patient Safety Plan rests with Barton Health's Governing Body, Board Quality Committee, Medical Executive Committee, and Patient Safety Committee.

Approval

This plan was approved by the following committees:

Patient Safety Committee on 12/18/2018

Board Quality on 1/3/2019

Section B:

2018 Patient Safety Priority Evaluation

In 2018, Barton Health focused on reducing falls across the organization, tubing connections, teamwork enhancement through TeamSTEPPS in the outpatient clinic settings, assessing communication in hand-offs/hand overs, and clinical alarms were prioritized.

The Fall Prevention Workgroup continued in 2018 with the goal of reducing falls across the organization. Post fall huddle forms were revised and/or developed for patient care areas with emphasis on risk factors relevant to each specific department. The associated Fall Prevention FMEA was completed with a 24-64% risk reduction across all participating departments. The group focused on falls with injury and analyzed trends of why they occurred. The organization experienced a paradigm shift with assisted falls, defined as a staff member guiding the individual to the ground, where they are now viewed as good catches. A workgroup of frontline team members will continue to work on implementing evidence-based fall prevention strategies in 2019.

Tubing misconnections were addressed by converting enteral products to meet new standards, and continually monitoring for ISO tubing product changes in accordance with California AB 1867, Joint Commission Sentinel Event Alert 53, and California Health and Safety Code 1279.7. In 2018, healthcare facilities including Barton Health remained awaiting the manufacture and distribution of neuraxial(NRFit®) tubing and syringes. Barton Health proactively communicated with vendors to ensure situational awareness around this product line change. At the end of 2018, there were no updates related to expected release and distribution of the NRFit® product line.

TeamSTEPPS tools were introduced to many outpatient departments in 2018. Departments were trained on the brief, huddle, and debrief tools and use these tools at the beginning, middle, and end of shifts respectively. System wide Daily Safety Briefs (DSBs), which are intended to increase safety awareness and enhance communication among interdepartmental teams in addition to supporting Barton Health's journey to becoming a high reliability organization, remained effective during 2018 and were extended to seven days a week. The program has been well received and highly successful.

Clinical alarms as related to NPSG.06.01.01 resulted in ongoing review with heightened attention focused on bedside capnography monitor alarms with the intent of reducing nuisance/false alarms. In an effort to mitigate nuisance alarms, work with the capnography vendor resulted in the addition of centralized monitors in OB allowing for enhanced monitoring of patients at risk for respiratory compromise. Data analytics on clinical alarms will continue to be reviewed and assessed in 2019 for further system optimization.

Finally, an FMEA on communication handoffs/handovers commenced in the second half of 2018. This multidisciplinary workgroup with frontline staff from clinical departments remains in the initial stages of the process with a literature review and best practices being vetted. This FMEA will continue in 2019.

Section C:

2019 Patient Safety Priorities

The Patient Safety Plan identifies and defines goals and specific objectives to be accomplished each year. In 2019, Barton Health's high priorities for Patient Safety include reducing medication errors across the organization, labor interruptions, tubing connections, teamwork enhancement through TeamSTEPPS, assessing communication in handoffs/hand overs, and clinical alarms.

Despite educational emphasis on human factors related to medication errors in 2018, medication errors remained in the top three categories of events reported in the safety learning system. Such errors can lead to patient harm with root causes comprising of many different factors within the complex medication ordering to administration process. 2019 will bring a renewed focus on medication safety from a multidisciplinary perspective with the goal of reducing errors that lead to harm and improving efficiencies related to this process across the healthcare organization.

Development of a robust plan around clinical labor interruptions will be a high priority for Barton Health in 2019. The minimization of disruption and addressing safety issues should a labor interruption occur is paramount to upholding the numerous processes comprising the patient safety program and ensuring a continuous, high quality patient experience. The formulation of this plan will assist in supporting safety programs presently in place while mitigating potential errors and patient harm within the healthcare organization.

Measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines will remain a priority in 2019. A complete conversion to the new ISO standard enteral feeding lines occurred in 2015. Manufacturers continue to distribute tubing that can be mistakenly interconnected. However, until connectors are reengineered, approved by the ISO and the FDA, and distributed throughout the healthcare industry, there remains the possibility of human error that can lead to patient harm. Barton Health proactively addresses prevention of adverse events associated with misconnecting IV, enteral and epidural lines through product purchasing and assessment of availability of connectors throughout the organization as well as staff education and awareness. It is anticipated neuraxial (NRFit®) connectors with redesigned incompatible connectors will become publicly available in 2019 at which time Barton Health will assess and convert to this new design to ensure compliance with California state law.

TeamSTEPPS teamwork enhancement program implementation will continue across the organization with a focus on bringing the specific tools of briefs, huddles, and debriefs to outpatient clinics that were not trained in 2018. TeamSTEPPS embraces leadership, communication, situation monitoring, and mutual support to enhance team performance and optimize patient outcomes. TeamSTEPPS Master Trainers will continue to integrate additional tools from the program into departments based upon readiness and need.

In 2019, the communication FMEA will continue within the organization to ensure best practices are implemented in accordance with The Joint Commission's Sentinel Event Alert 58. The overall goal will be to enhance patient handoff/handover communication among team members.

Barton Health will continue to prioritize NPSG.06.01.01 focusing on clinical alarm system safety in 2019. While alarms in the clinical setting that are non-actionable can result in alarm fatigue for team members, bedside capnography monitoring alarms remain an area for further optimization. Therefore, specific focus will continue to be placed on bedside capnography monitoring data analytics related to nuisance/false alarms.

Results from the AHRQ Hospital Survey on Patient Safety Culture performed at the end of 2018, with the intent of measuring conditions that can lead to adverse events and patient harm, will be analyzed. Based on the findings, action items may focus on enhancing staff awareness about patient safety, identifying strengths and opportunities for improvement, evaluating trends in culture changes, and assessing impact of patient safety initiatives and interventions.

Finally, in order to move forward Barton Health's high reliability journey, Just Culture program education with all providers and staff members is planned for 2019. To ensure program sustainment, Just Culture will be integrated into new hire orientation.

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Appendix A:

***2019 Lake Tahoe Surgery Center
Patient Safety Plan***

This plan was created and revised by the Lake Tahoe Surgery Center Patient Safety Committee, a subcommittee of Barton Health's Patient Safety Committee. Implementation of this plan is intended to optimize healthcare patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events. This Patient Safety Plan ensures that Barton Health implements and maintains a patient safety program in accordance with The Joint Commission standards, Nevada Revised Statutes (NRS), Patient Safety and Quality Improvement Act of 2005, and other regulatory agencies.

Patient Safety Plan
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Table of Contents

Commitment to Patient Safety..... 25

Mission, Vision, and Values..... 25

Scope and Purpose..... 25

Roles and Responsibilities..... 27

Objectives and Goals of the Patient Safety Plan..... 30

Components and Methods..... 32

Model for Improvement..... 35

Data Collection and Reporting..... 36

Ongoing Reporting and Review..... 36

Assessment of the Patient Safety Plan..... 37

Patient Safety Checklists and Patient Safety Policies..... 37

Approval of Patient Safety Plan..... 38

2019 Lake Tahoe Surgery Center Patient Safety Priorities..... 39

References..... 40

LTSC Attachment A: Terms and Definitions..... 41

LTSC Attachment B: Patient Safety Checklists & Policies for Lake Tahoe Surgery Center..... 43

Commitment to Patient Safety

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

Mission, Vision, and Values

In support of the mission, vision, values, and strategic plan of Barton Health, Lake Tahoe Surgery Center's Patient Safety program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.
- An environment and culture where patients, families, staff and leaders within the organization identify and manage actual and potential risks to patient safety thereby resulting in zero harm.
- An ongoing proactive reduction in health-related errors including near miss and good catch events.
- Integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions, and services.

Scope and Purpose

The scope of this Patient Safety Plan is specific to Lake Tahoe Surgery Center, a department of Barton Health, which includes but is not limited to:

- Patient safety
- Visitor safety
- Employee safety

All Lake Tahoe Surgery Center staff are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process. Each employee performs a critical role in patient safety and thus, Barton Health's journey to becoming a high reliability organization. All Barton Health-Lake Tahoe Surgery Center team members are focused on providing consistently exceptional care through an environment that supports teamwork, collaboration and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to patient safety while setting expectations for those who work in the organization. Leadership evaluates the culture of safety on a regular basis.

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

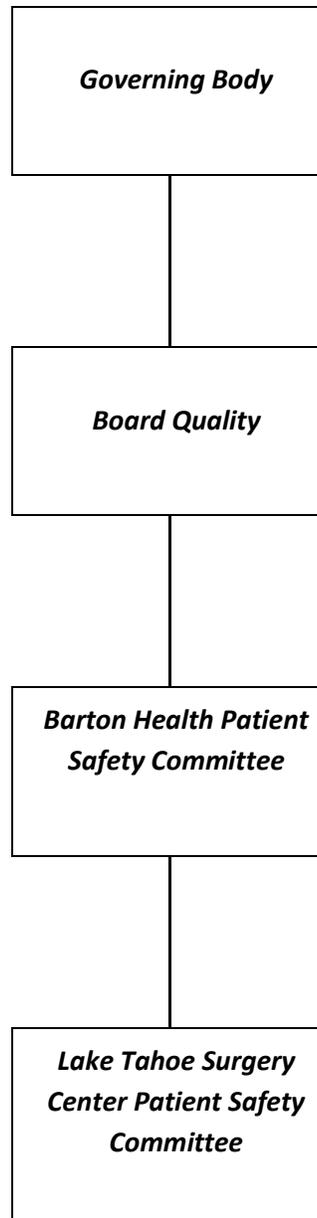
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff.

Roles and Responsibilities

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

The Patient Safety Committee reporting hierarchy:

***Roles and Responsibilities***

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
 - The Patient Safety Officer of the medical facility. At Barton Health, the Director of Patient Safety has oversight of the Patient Safety Officer and serves in this role;
 - The infection preventionist of the medical facility;
 - At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and

- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

Lake Tahoe Surgery Center Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least quarterly, due to the number of employees in the facility, report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Lake Tahoe Surgery Center Patient Safety Committee will meet quarterly to accomplish the following:

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

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

RCA Team Leader/Facilitator Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create a RCA process that incorporates Patient Safety Improvement elements.

Director of Patient Safety (based on NRS 439.870)

- Provide oversight to the integrated Barton Health patient safety program.
- Serve on the Lake Tahoe Surgery Center patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the Lake Tahoe Surgery Center Patient Safety Committee, Patient Safety Committee, Board Quality and Governing Board actions taken related to the sentinel event.
- Ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.
- Oversee, monitor and evaluate safety activities, manage the program that measures and analyzes safety levels, and help identify problem areas for correction
- The Director of Patient Safety has the authority to intervene in any clinical or non-clinical activity which poses an actual or potential negative outcome to a patient's well-being. The Director of Patient Safety involves leadership in the creation, initiation and evaluation of corrective action measures for event resolution.
- Report to the Patient Safety Committee regarding any action taken in accordance with the responsibilities above.

Infection Preventionist Responsibilities (based on NRS 439.873)

- Serve on the Lake Tahoe Surgery Center patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number of infections at the facility.
- Take such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Executive Member Responsibilities

- Provide vision and leadership to the Lake Tahoe Surgery Center Patient Safety Committee and develop and foster a safe learning and improving culture.
- Provides oversight to the integrated patient safety program
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient

safety action plans.

- Ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.

Objectives and Goals of the Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
To control known and potential safety hazards to patients, visitors, and staff.	Strive for zero harm.	Patient Safety Plan as presented	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To establish a safety program that incorporates all activities within Lake Tahoe Surgery Center which contribute to the maintenance and improvement of staff and patient safety and reduction of medical/health care errors.	Provide education to all staff on the elements of the Lake Tahoe Surgery Center Patient Safety Plan.	Education provided upon hire	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

To create a culture in which patients, visitors and employees can identify and manage actual and potential risks to patient and staff safety.	In-service all personnel on the use and completion of event reports.	Education provided upon hire	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To develop a culture that encourages recognition and acknowledgement of risks to safety including medical health care errors, facility-acquired infections, initiation of actions to reduce risks, internal minimization of individual blame or retribution, and organizational learning about errors.	Reduce the risk of safety related incidents by proactively evaluating systems in place and making any necessary changes.	Evaluate near-miss events through RCAs and PIs presented at Patient Safety Committee and encourage Just Culture changes	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To develop an environment that supports sharing of knowledge to affect behavioral changes in itself and other healthcare organizations to improve patient safety.	Reduce the risk of safety related incidents by proactively evaluating systems in place and making any necessary changes.	Evaluate near miss events through RCAs and PIs presented at Patient Safety Committee and encourage Just Culture changes	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

Empower patients to understand and participate in their healthcare.	Provide communication and education to patients relating to their care.	Provide education through various methods based on learning assessment.	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
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Components and Methods

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

Patient Safety Risk Reduction

Several approaches are utilized at Barton Health to reduce the risk of a patient safety event. The Joint Commission’s National Patient Safety Goals, National Healthcare Safety Network (NHSN) Institute for Healthcare Improvement (IHI), Agency for Healthcare Research and Quality (AHRQ), Hospital Quality Institute, and California Hospital Patient Safety Organization (CHPSO) are some examples of utilized resources to prevent and reduce the likelihood of serious patient safety events. Sentinel Event Alerts released through The Joint Commission are also analyzed for compliance.

Sentinel Event Alerts

Sentinel Event Alerts, published through The Joint Commission, are communicated through the Patient Safety Committee. Compliance status and opportunities for improvement are addressed through workgroups consisting of affected Department Directors, Executive Team Members and others as appropriate to formulate risk reduction strategies and follow up through an action plan. Action items within the action plan are assigned to individuals who are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

Scientific Model Integration

The patient safety program has been developed with scientific knowledge in a foundational aspect including concepts from:

- Shewhart cycle or Model for Improvement (Plan, Do, Study, Act –PDSA)
- Failure Mode and Effects Analysis (FMEA)
- Re-engineering (Human factor re-engineering such as signage for High Alert Medications, Pop up alert in Pyxis medication dispensing system, Tall man lettering for look-alike sound alike drugs in medication usage process, etc.)
- Rapid Cycle Improvement (Institute of Health Care Improvement (IHI)) Collaborative approach termed the

'Breakthrough Series', to bring about rapid cycle improvements. Fundamental to the collaborative approach is the acceptance of a model and establishment of infrastructure through which collaborating organizations can identify and prioritize aims for improvement and gain access to the methods, tools, materials etc.)

- RCA²: Improving Root Cause Analyses and Actions to Prevent Harm
- Process Improvement (PI) such as Lean and Six Sigma concepts
- Evidence-based practice and clinical practice guidelines

Educational Enhancement Activities

The Patient Safety Plan provides the opportunity to reduce patient safety events and hazardous conditions through education, proper and effective orientation, and annual training. Barton Health's clinical orientation program emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing patient safety training for Barton Health team members including practitioners is offered through various teaching strategies including, but not limited to, bulletin boards, online learning formats, skills labs, and didactic experiences. Program content may include education specific to patient safety related events or advancements in patient safety practice. As appropriate, this training incorporates methods of team training such as TeamSTEPPS by AHRQ to foster an interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and mechanisms to report patient safety concerns.

Investigation: Root Cause Analysis and Process Improvements

In any event when an adverse/sentinel event or hazardous condition has occurred, the issue is revisited and the status mitigated through a risk reduction strategy using the Root Cause Analysis (RCA) process. Lesser events are managed through either an RCA or Process Improvement (PI). Reportable Adverse or Sentinel Events shall be subject to an immediate in-depth RCA.

RCAs shall be convened by the Director of Patient Safety or designee and includes team members either directly or indirectly involved in the event. Members from uninvolved departments may be invited to provide additional information. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting the RCA. The Root Cause Analysis and Action Plan Framework Table, introduced by the Joint Commission, contains 24 analysis questions that guide the organization through the steps in a root cause analysis. Not all the questions apply to all the events or cases. The 5 Whys technique will be used to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. During the RCA, events are deconstructed in an effort to identify the key causes that may have contributed to the event. The deconstruction process leads to action items designed to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors. The Veterans Affairs National Center for Patient Safety Action Hierarchy is used to assure strong corrective action items are identified.

An RCA meeting will meet as needed to accomplish the following:

Define the healthcare issues or potential risks.

- Conduct Root Cause Analysis
 - Review and analyze the data.
 - Review the RCA process and improvement related activities and timelines.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan

- Discuss corrective action process and activities.
- Discuss and present possible changes in procedure to improve areas indicated.
- Identify strengths and areas that need improvement.
- Develop strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

Process Improvement teams are formed when an issue affecting more than one service line is identified and a near miss may or may not be involved. There may be no adverse patient outcome in connection with the event, however, the potential for a patient event should the issue recur is likely. PIs may also result from discussions during RCAs where a system improvement process is identified as a result of a patient event. Team members convene and identify key factors involved in the process through deconstruction that may have contributed to the situation and create action items to mitigate the identified issues.

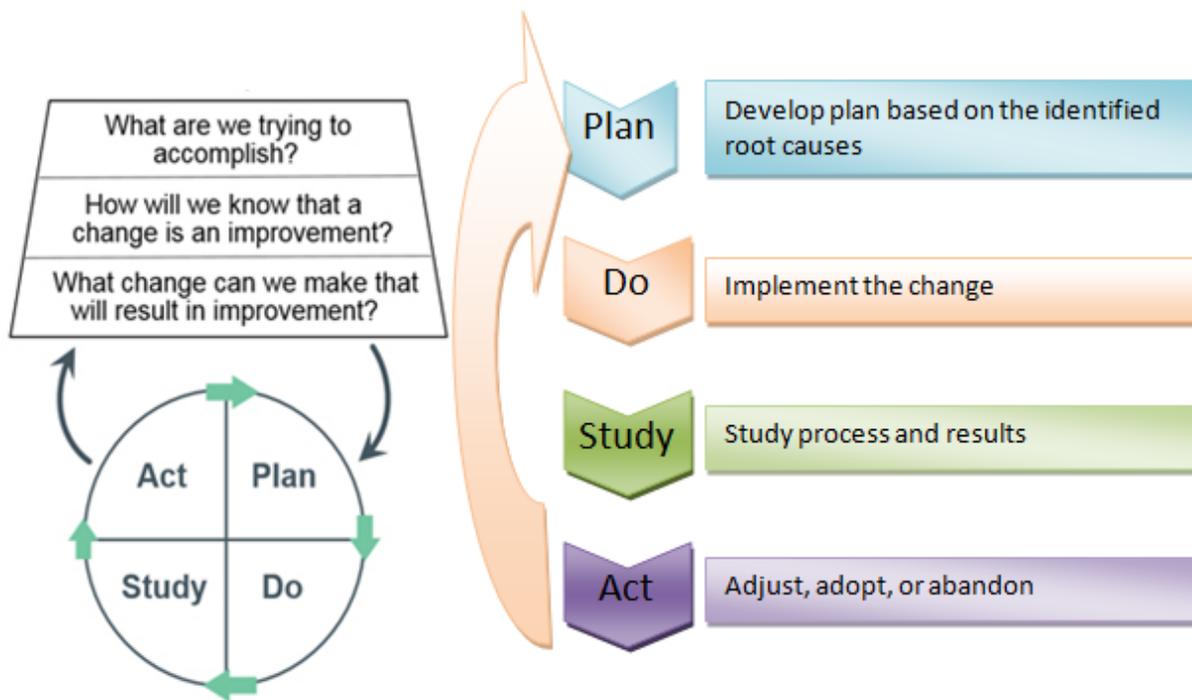
RCA and PI workgroups construct action items and assign them to appropriate individuals for completion. Staff involvement is considered essential, since they are the team members on the front line with the most knowledge of the actual day-to-day workings of the processes. Individuals assigned action items are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

As a learning organization utilizing Just Culture, Barton Health focuses on systems and processes, not individuals, during RCA or PI event review.

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

Model for Improvement

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



The cycle is defined as follows:

- **Plan**--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- **Do**--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- **Study** -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- **Act**--If the result is successful or desirable, standardize the changes and then work on the next prioritized

problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive patient safety efforts. Lake Tahoe Surgery Center utilizes an electronic event reporting system for tracking events, sentinel events, healthcare infection data, and information for internal data collection.

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

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

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report as needed 2) Severity of infection report as needed 3) RCA assessment as needed	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Patient Safety Plan update 2) Review and revise Patient Safety checklists and policies

Assessment of the Patient Safety Plan

The Patient Safety Committee shall review and assess/approve this plan at least once a year, but more often as necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices.

Patient Safety Checklists and Patient Safety Policies

In accordance with [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure the patient's room and environment is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

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

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

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

The patient safety checklists are listed in LTSC Attachment A.

The patient safety policies are listed in LTSC Attachment B.

Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. At Barton Health, this is accomplished by the plan being approved through the Lake Tahoe Surgery Center Patient Safety Committee, the Barton Health Patient Safety Committee, Board Quality and the Governing Board. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

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

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

Authority

The authority to implement the Patient Safety Plan rests with Barton Health's Governing Body, Board Quality Committee, Medical Executive Committee, and Patient Safety Committee.

2019 Lake Tahoe Surgery Center Patient Safety Priorities

During 2019, Lake Tahoe Surgery Center will strive to achieve two different priorities to ensure safe patient care. During 2018, the surgical site infection rate was zero. Staff education was provided during the year. In 2019, LTSC would like to maintain a surgical site infection rate of less than 0.5%.

Lake Tahoe Surgery Center had zero never events during 2018. In an effort to reduce the potential for harm, Lake Tahoe Surgery Center will strive to maintain zero harm during 2019. Physician and staff education is ongoing. The patient safety committee reviews all event reports and action items will be assigned to the appropriate staff. Education will occur immediately following an event, near miss or good catch.

References

Agency for Healthcare Research and Quality. (2014). *The patient safety and quality improvement act of 2005*. Retrieved from <http://www.ahrq.gov/policymakers/psoact.html>

Centers for Disease Control and Prevention's National Healthcare Safety Network. (2018). *Healthcare-associated infections (HAIs)*. Retrieved from <http://www.cdc.gov/hai/>

Nevada Division of Public and Behavioral Health. (2016). *Sentinel event registry*. Retrieved from [http://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_\(SER\)-Home/](http://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_(SER)-Home/)

Nevada Revised Statutes. Health and safety of patient at certain medical facilities. NRS 439.800-439.890

The Joint Commission Standard APR.09.02.01

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The Joint Commission. (2018). *2019 National Patient Safety Goals*. Retrieved from http://www.jointcommission.org/standards_information/npsgs.aspx

U. S. Department of Veterans Affairs. (2015). *Root cause analysis tools*. Retrieved from http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf

LTSC Attachment A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#)):

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Acquired Infection ([NRS 439.802](#)):

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#)):

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place for greater than 2 calendar days on the date of event, with day of device placement being Day 1, and an indwelling urinary catheter was in place on the date of event or the day before. If an indwelling catheter was in place for greater than 2 calendar days and then removed, the date of event for the UTI must be that day of discontinuation or the next day for the UTI to be catheter-associated (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN): Patient Safety Component Manual; 2017. Available at https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

LTSC Attachment B: Patient Safety Patient Safety Checklists & Policies for Lake Tahoe Surgery Center**REPORT TO THE DIRECTOR OF THE LEGISLATIVE COUNSEL BUREAU PURSUANT TO ASSEMBLY BILL 280 OF THE 2011
LEGISLATIVE SESSION – SUBMITTED BY:**

Lake Tahoe Surgery Center

212 Elks Point Rd Suite 201, Zephyr Cove NV 89448

Lindsey Wharton RN, Director and Administrator of Perioperative Services

YEAR – June 1, 2018 – June 30, 2019

Check Lists Include:	Developed	Revisions*	Usage**	Review***
Related to the following specific types of treatments*		(date of revision)	(Unit/department)	
Patient Room & Environment Sanitation (Cleaning Checklists)		June 29, 2015	ASC	X
Discharge Checklist		October 28, 2014	PACU	X (on EMR)
Pre-op Checklist		May 2, 2015	PRE-OP/OR	X (on EMR)
Safety Checklist	May 2, 2015	June 1, 2016	OR	X (on EMR)
Sign-In	May 2, 2015	June 1, 2016	OR	X (on EMR)
Fire Safety	May 2, 2015	June 1, 2016	OR	X (on EMR)
Timeout	May 2, 2015	June 1, 2016	OR	X (on EMR)
Sign-out	May 2, 2015	June 1, 2016	OR	X (on EMR)
Environmental Rounds (quarterly)		November 3, 2015	ASC	X
Infection Control Survey (monthly)			ASC	X
Surgical Services Audit		June 29, 2015	ASC	X
Incubation Temperature			STERILIZATION	X
Medication Refrigerator		May 2013	PRE-OP/PACU/OR	X
IVF/Blanket Warmer Temperature		April 25, 2016	PRE-OP/PACU/OR	X
Sage Warmer		February 3, 2016	PRE-OP	X
OR Temperature/Humidity		December 18,	ASC	X

		2014		
Washer Sterilizer Cleaning			STERILIZATION	X
Daily, weekly, monthly duties		April 21, 2016	PRE-OP/PACU/OR	X
Crash Cart		May 2018	NURSING	
Pediatric Crash Cart		May 2018	NURSING	
Malignant Hyperthermia Cart		January 25, 2016	NURSING	X
Hand Hygiene Audit			ASC	X
Medication Labeling Audit		December 8, 2016	ASC	
Patient Safety Policies Include:	Developed	Revisions	Usage	Review
Patient Identification			ASC	X
Hand Hygiene		December 20, 2017	ASC	X
Patient Safety Checklist			ASC	X
National Patient Safety Goals		2018	ASC	
Medication Reconciliation			ASC	X
Handoff Communication			ASC	X
Universal Protocol			ASC	X
Safe Preparation and Administration of Medications		April 2018	ASC	
General Safety Policy- Patients/employees			ASC	X
Hazard Communications			ASC	X
Injury and Illness Prevention Program Plan			ASC	X
OSHA Reporting/Injury Reporting			ASC	X
Material Safety Data Sheets			ASC	X
Exposure Control Plan			ASC	X

Abusive Behavior- Patients			ASC	X
Abusive Behavior- Non-patients			ASC	X
Disruptive Physician or Ancillary staff Behavior			ASC	X
Identification of Life Safety Code Deficiency			ASC	X
Fire Risk Assessment			ASC	X
Summary of Review	Total # developed	Total # revised	Total # Reviewed	
Patient Safety Checklists	0	2	21	
Patient Safety Policies	0	3	16	

*Checklists and Patient Safety Policies were reviewed for the stated time period. Need for revision is noted by the date the revision was made.

**Usage outlines the unit/departments the checklists are used in.

***As part of the annual review any required revisions will be identified. If revisions are required this is noted in the revision box. Any additional patient safety checklists or policies identified will be noted in this (review) column. If the annual review reveals no changes are required this box will be marked with an "X". An "X" means that the checklists and policies were reviewed but no changes were required.

Reports are due on or before July 1 of each year

The mission of Desert Willow Treatment Center is to provide quality, individualized mental health services in a safe and culturally sensitive environment collaborating with caregivers, community and other providers to ensure that children and families of Nevada may achieve their full human potential.

Desert Willow Treatment Center

QUALITY AND PATIENT SAFETY PLAN

DATE: 2019
VERSION: 3



This plan was created and revised by the Desert Willow Treatment Center Patient Safety (Care of Patient) committee/team with coordination with applicable Continuing Quality Improvement Teams. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Contents

Commitment to Patient Safety.....	2
Mission	2
Scope and Purpose.....	2
Roles and Responsibilities.....	3
Roles and Responsibilities	4
Objectives and Goals of the Quality and Patient Safety Plan	7
Components and Methods	8
Root Cause Analysis.....	8
Model for Improvement.....	9
Data Collection and Reporting.....	10
Assessment of the Quality and Patient Safety Plan	11
Patient Safety Checklists and Patient Safety Policies	11
Approval of Patient Safety Plan.....	13
References	13
Appendix A: Terms and Definitions	14
Appendix B: Patient Safety Goals	16
Appendix C: Fishbone Diagram.....	17
Appendix D: Checklists	18
Appendix E: Related Policies	19

**Patient Safety Committee/Care of Patient
Desert Willow Treatment Center**

6171 W. Charleston Blvd, Building 17
Las Vegas, NV 89146
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Commitment to Patient Safety

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

Mission Statement

The mission of Desert Willow Treatment Center is to provide quality, individualized mental health services in a safe and culturally sensitive environment collaborating with caregivers, community and other providers to ensure that children and families of Nevada may achieve their full human potential.

In support of our mission Desert Willow Treatment Center Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in Desert Willow Treatment Center are required to fully support and participate in this plan and devote their expertise to the patient safety and healthcare quality improvement process.

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

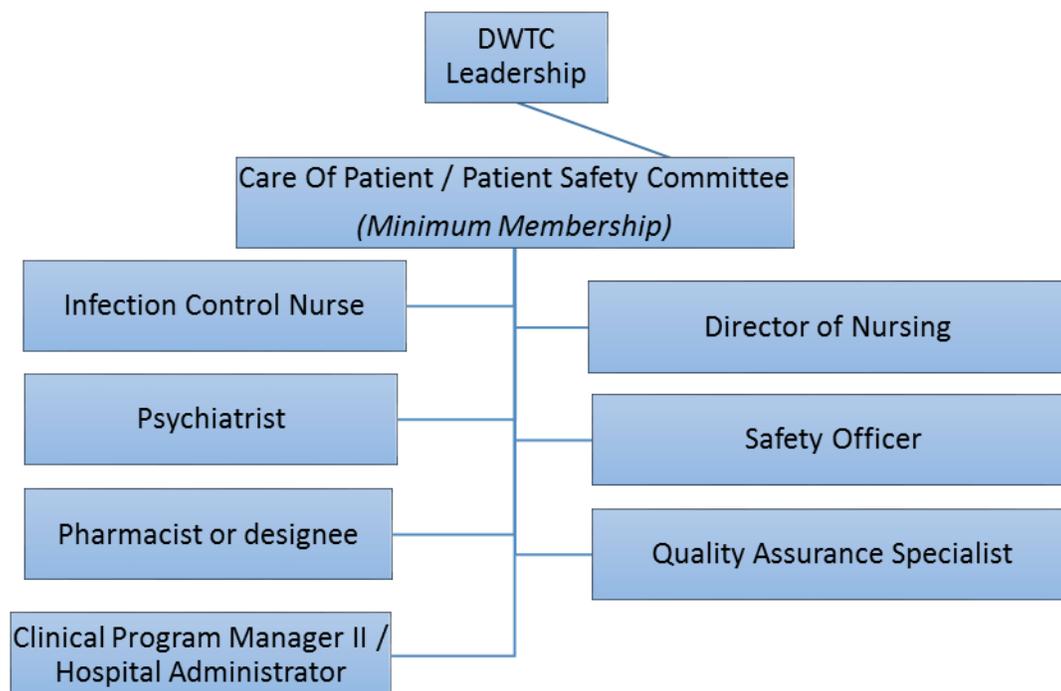
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

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

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully. Desert Willow Treatment Center's Care of Patient Committee serves as the Patient Safety Committee.

The Patient Safety Committee Organization



Roles and Responsibilities

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

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

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

Root Cause Analysis (RCA) Team

A Root Cause Analysis Team will be established following a Sentinel Event or any other event determined by Leadership as requiring a Root Cause Analysis.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.

- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

RCA Team Membership:

- DCFS Administrator will identify a Root Cause Analysis team leader who is not a current employee of Desert Willow Treatment Center
 - RCA team leader Responsibilities:
 - Organize and coordinate the RCA process.
 - Assemble and encourage a supportive and proactive team.
 - Assign investigative and implementation tasks to the team members.
 - Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
 - Desert Willow Treatment Center Quality Assurance Specialist
 - Desert Willow Treatment Center Safety Officer or designee
 - Representation from the following disciplines within Desert Willow Treatment Center
 - Psychiatric Nurse
 - Mental Health Technician
 - Clinical Staff
 - Depending on the event other disciplines may be required
 - DCFS Administrator, Deputy Administrator or Clinical Program Manager II may request additional representation from other agencies, disciplines or programs

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.

- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.
- Communicate the progress of any infection control investigations, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process for infection control that incorporates the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities (Clinical Program Manager II / Hospital Administrator)

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

The Patient Safety Committee/ Care of Patient Team will meet monthly to accomplish the following:

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

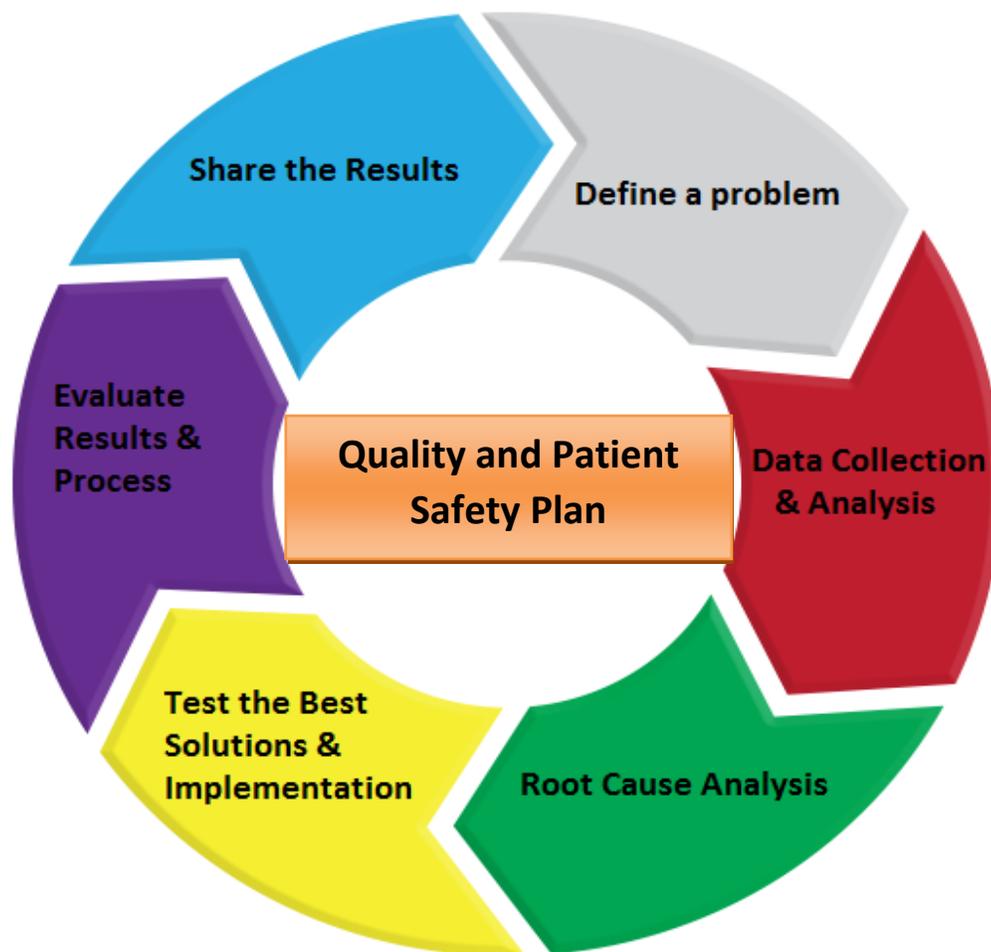
Objectives and Goals of the Quality and Patient Safety Plan

- National Patient Safety Goals guide the service delivery process.
 - Identify Patients Correctly. Use at least two identifiers when providing care, treatment or services.
 - Use Medications Safely. While administering oral medications, observe patients to ensure that they have swallowed the medication(s). Maintain and communicate accurate medication information through medication reconciliation. Provide the patient and guardian with written information on the medication (dose, frequency, route, purpose) the patient should be taking and the importance of giving a list to his/her primary care physician.
 - Reduce the risk of health care-associated infections
 - Identify risks for acquiring and spreading infections
 - Comply with the CDC hand hygiene guidelines. Monitor hand hygiene practices. Set goals and improve compliance with hand hygiene guidelines.
 - Increase staff influenza vaccination rates
 - Annually evaluate the effectiveness of the infection control and surveillance plan
 - Identify Patients at risk for suicide. Conduct a risk assessment that identifies specific characteristics of the patient served and environmental features that may increase or decrease the risk for suicide. Assess the immediate safety needs and most appropriate setting for treatment for each patient. Identify patient safety risks. Identify protective factors that decrease risk of suicide. When an individual at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and family.
- Sentinel Events
 - Identify and Resolve Safety Risks for Patients including Environmental Factors
 - Root cause analysis will be done if sentinel event occurs
- Medication Management to include but not limited to:
 - Monitoring processes for high alert and look-alike/sound-alike medications
 - Reviewing the storage of medication, including expiration and temperatures
 - Reviewing appropriateness of drug order
 - Monitoring medication effects, adverse medication reactions and medication errors
 - Monitoring management of unused/expired medication
 - Monitoring Food/Drug/Drug interaction
 - Reviewing after hours dispensing and administration of medications
 - Providing medication education and handouts
 - Reconciling medication information including recording and passing along correct medication information to healthcare providers
- Nutrition Services
 - Provide balanced meals in compliance with the National School Lunch Program
 - Provide all patients with a working knowledge of the basic principles of nutrition and appropriate exercise while addressing potential dietary issues or medical concerns.
- PBIS
 - Continue to implement, evaluate effectiveness and consistency of PBIS program.
 - Update the program as necessary.
- Staffing
 - Take acuity into consideration when staffing the units.

Components and Methods

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

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



Root Cause Analysis

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

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

conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Desert Willow Treatment Center to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram. 5 Why’s technique also can be used to drill down the problem and find the root causes.

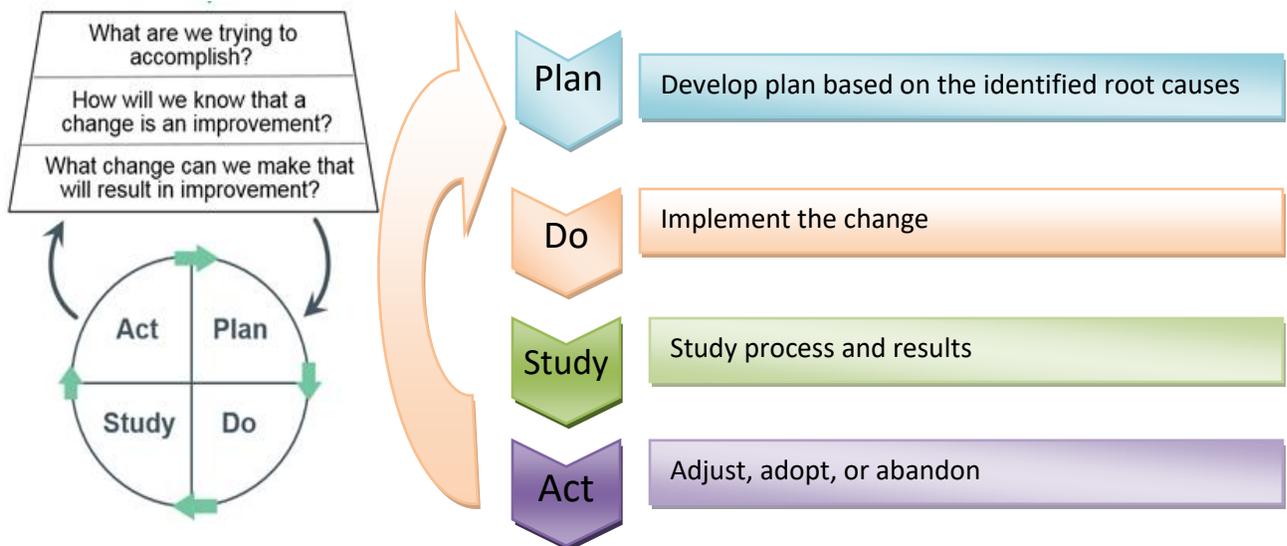
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) may be used for analyzing the problems. You may use the fishbone diagram individually to analyze the root causes or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics.

Model for Improvement

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



The cycle is defined as follows:

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

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

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

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

Data Collection and Reporting

Data should drive any quality and patient safety effort. Desert Willow Treatment Center is using DCFS Incident/ Accident Reports for tracking sentinel events, healthcare infection data, and Microsoft Excel and Access for internal data collection.

Data is submitted to the following external reporting entities:

- BHCQC: Bureau of Health Care Quality and Compliance
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- DPBH: Department of Public and Behavioral Health
- Southern Nevada Health District
- State of Nevada Child Death Review Team
- TJC: The Joint Commission
- LCB: Legislative Council Bureau

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report	1) Severity of infection report	1) Quality and Patient Safety Plan update
2) Severity of infection report	2) Review and evaluate the measure of improvement of patient safety	2) Checklists and Policies reviewing and revising
3) RCA assessment	3) Review and evaluate the measurement to prevent and control infections	

Assessment of the Quality and Patient Safety Plan

Quarterly Incident Accident Report including Trigger Identification reported to the Performance Improvement Team and to Leadership

Quarterly Consumer Complaint Report reported to Ethics Rights and Responsibilities Team and to Leadership

Infection Control information reported to Patient Safety Committee/Care of Patient Team and to Leadership

Root Cause Analysis for any Sentinel Event reviewed by all appropriate committees and to Leadership

Corrective Action Plans reviewed by all appropriate committees and Leadership

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;

- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

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

The patient safety checklists are listed in Appendix D.

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit – The Joint Commission
https://www.jointcommission.org/framework_for_conducting_a_root_cause_analysis_and_action_plan/
- Department of Public and Behavioral Health Sentinel Event Reporting
<https://dpbhrdc.nv.gov/redcap/>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Appendix B: National Patient Safety Goals

2019 Behavioral Health Care National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify individuals served correctly

NPSG.01.01.01 Use at least two ways to identify individuals served. For example, use the individual's name *and* date of birth. This is done to make sure that each individual served gets the correct medicine and treatment.

Use medicines safely

NPSG.03.06.01 Record and pass along correct information about an individual's medicines. Find out what medicines the individual served is taking. Compare those medicines to new medicines given to the individual served. Make sure the individual served knows which medicines to take when they are at home. Tell the individual served it is important to bring their up-to-date list of medicines every time they visit a doctor.

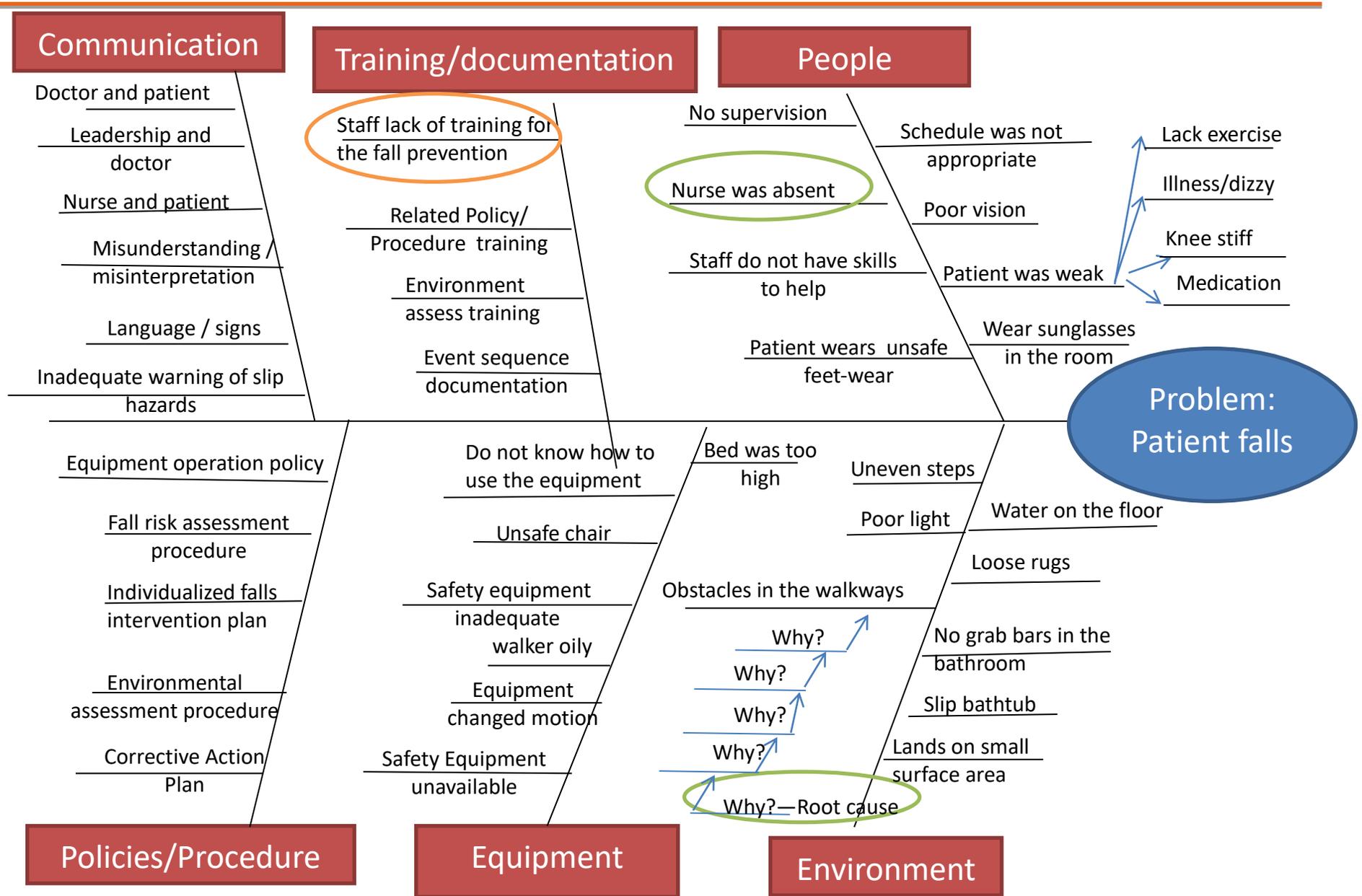
Prevent infection

NPSG.07.01.01 Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

Identify individuals served safety risks

NPSG.15.01.01 Find out which individuals served are at risk for suicide.

Appendix C: Fishbone Diagram



Appendix D: Checklists

Universal Assessments A & B

<S:\DWTC\DWTC FORMS\DWTC 18A Universal Assessment Part A Rev 08-16.doc>

<S:\DWTC\DWTC FORMS\DWTC 18B Universal Assessment Part B Rev 12-08.doc>

Personal Safety Assessment <S:\DWTC\DWTC FORMS\DWTC 163 Personal Safety Assessment 12-17.docx>

Pediatrician History & Physical Examination:

<S:\DWTC\DWTC FORMS\DWTC 19 Pediatrician Admission History and Physical Examination 02-18.docx>

Aftercare Plan Located in Avatar (Electronic Health Record System)

ILSM Assessment Tool <S:\DWTC\DWTC FORMS\DWTC 192 Interim Life Safety Measure Assessment Tool 9-16.docx>

Monitoring Sheet <S:\DWTC\DWTC FORMS\DWTC 31 Patient Monitoring Sheet 6-17.xlsx>

Hygiene Monitoring Form <S:\DWTC\DWTC FORMS\DWTC 183 Hygiene Monitoring form 11-17.docx>

Incident Accident Form

[S:\DWTC\DWTC FORMS\DWTC 72 Incident Accident Report 03-18 \(Print Two-Sided on Pink Paper\).pdf](S:\DWTC\DWTC FORMS\DWTC 72 Incident Accident Report 03-18 (Print Two-Sided on Pink Paper).pdf)

Peer Review Forms

<S:\DWTC\DWTC FORMS\DWTC 141C CREDENTIALLED RN PEER REVIEW 09-16.doc>

<S:\DWTC\DWTC FORMS\DWTC 141 - CREDENTIALLED STAFF PEER REVIEW - PSYCHIATRIST 03-09.doc>

Medication Pass Audit <S:\DWTC\DWTC FORMS\DWTC 180 Medication Pass Audit 09-17.docx>

Unit Safety Contraband Checklist <S:\DWTC\DWTC FORMS\DWTC 182 Unit Safety Contraband Checklist 09-16.docx>

Temperature Logs:

<S:\DWTC\DWTC FORMS\DWTC 120 A - Food Refrigerator-Freezer Temperature Log 05-18.doc>

<S:\DWTC\DWTC FORMS\DWTC 120 B - Medication Refrigerator Temperature Log 05-18.doc>

<S:\DWTC\DWTC FORMS\DWTC 120 C - Medication Room Temperature Log 6-17.doc>

Ebola Screening Tool <S:\DWTC\DWTC FORMS\DWTC 184 Ebola Screening Tool 04-16.docx>

Infection Surveillance Report <S:\DWTC\DWTC FORMS\DWTC 73 Infection Surveillance Report 02-17.docx>

Environment of Care Monitors

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\10.0 - ENVIRONMENT OF CARE\10.50 - ENVIRONMENT OF CARE MONITORS 03-18.docx>

Suicide Risk Assessment

[S:\DWTC\DWTC FORMS\DWTC 195A Suicide Risk Assessment & Safety Plan \(Admission\) 11-17.docx](S:\DWTC\DWTC FORMS\DWTC 195A Suicide Risk Assessment & Safety Plan (Admission) 11-17.docx)

[S:\DWTC\DWTC FORMS\DWTC 195B Suicide Risk Assessment \(Weekly\) 11-17.docx](S:\DWTC\DWTC FORMS\DWTC 195B Suicide Risk Assessment (Weekly) 11-17.docx)

[S:\DWTC\DWTC FORMS\DWTC 195C Suicide Risk Assessment & Safety Plan \(Discharge\) 11-17.docx](S:\DWTC\DWTC FORMS\DWTC 195C Suicide Risk Assessment & Safety Plan (Discharge) 11-17.docx)

Appendix E: Related Policies

DWTC Policy 1.19 Risk Management Plan

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\01.0 - ORGANIZATION\1.19 - RISK MANAGEMENT PLAN.doc>

DWTC Policy 4.32 Root Cause Analysis

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\04.0 - QUALITY ASSURANCE\4.32 - ROOT CAUSE ANALYSIS.doc>

DWTC Policy 4.33 Sentinel Events

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\04.0 - QUALITY ASSURANCE\4.33 - SENTINEL EVENTS 6-15.doc>

DWTC Policies included in Chapter 10 - Environment of Care

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\10.0 - ENVIRONMENT OF CARE>

10.01 Guidelines Hepatitis B Vaccine Program	10.53 Security Management Plan
10.02 Influenza Program	10.54 Hazardous Materials and Waste Management Plan
10.03 Occupational Exposure to Bloodborne Pathogens	10.55 Fire Safety Plan (previously Life Safety Management Plan)
10.04 Infection Control of Ice Machine	10.56 Emergency Management Plan
10.05 Health Safety Inspection	10.57 Utility Systems Disruption
10.06 Soiled Linen and Laundry Handling	10.58 Medical Equipment Management Plan
10.07 Interim Life Safety Measures	10.59 Emergency Codes / Public Address System
10.08 Use of Disposable Gloves During Handling of Foods and Fluids	10.60 Distribution of Linens
10.09 Janitor's Closet	10.62 Non-Dairy Beverage Substitutions
10.10 Surveillance, Prevention and Control of Infection Guidelines	10.63 Diets and Food Requisitions
10.11 Personal Protective Equipment	10.64 Meals DWTC
10.12 Housekeeping Procedures for Infection Control	10.66 Nutritional Screening and Assessment
10.13 Work Practice Controls	10.68 Dietetic Services Quality Improvement Plan
10.14 Lice Policy	10.69 Diet Orders
10.15 Hand Washing	10.70 Wellness Policy
10.16 Tuberculosis Screening for Patients	10.73 Nutrition Care Monitoring
10.17 Sanitation and Disinfection	10.74 Nutrition Care Manuals and Menu
10.18 Isolation Techniques	10.75 Nutrition Education
10.19 Nosocomial Detection and Reporting	10.76 Meal Service
10.20 Occupational Illness	10.77 National School Lunch Program
10.21 Infection Control and Surveillance Plan	10.81 Incident-Accident Reporting
10.22 Standard Precautions	10.83 Incidents Involving State Vehicles
10.23 Transmission Based Precautions	10.85 Lockout-Tagout System
10.24 Disinfecting Patients' Recreational Objects	10.86 Employee Lockers
10.25 Emergency Preparedness External Disaster	10.87 Guests of DWTC
10.40 Maintenance Stand-By for After Hours	10.91 911 Emergency Protocol
10.41 Housekeeping/Maintenance	10.92 Building Security
10.42 Maintenance Repair Requests	10.93 Treats / Behavioral Emergencies in the Lobby / Intake Room
10.44 Use of State Vehicles	10.94 Natural Gas Leak
10.46 Non-Smoking/Smoking	10.95 Potentially Dangerous Weapons
10.47 Ordering of Supplies	10.96 Bomb Threats
10.50 Environment of Care Monitors	10.99 Chemical Ingestion by Patient
10.51 Safety Management Plan	10.100 Hostage Situation
10.52 Utility Systems Management Plan	10.101 CCSD / DWTC Evacuation
	10.102 Decorations

Facility Name: Parkway Surgery Centers	Policy And Procedure Guideline Name: Safety Management Program (Environment Of Care)	Policy Number: SAFE 104
	Subject Category: SAFETY	Effective Date: 12/01/2016
		Revised Date: 12/14/2017, 1/10/19
		Page 1 Of 4 (Update Field)

Policy: The facilities shall provide guidelines and implement proactive practices, which provide a safe environment of care in relation to property, equipment, patients, personnel and the public.

Purpose: The reduction of physical hazards and the implementation of safe practices enhance environmental safety.

Procedure Guidelines:

Responsibility:

1. Employees are responsible for:
 - A. Intervention when, safety conditions pose a threat to life or health, or threaten damage to equipment or buildings.
 - B. The continuing maintenance of the facility property, eliminating hazards upon discovery.
 - C. Reporting equipment or maintenance problems and incidents of property damage to the Safety Officer or Administrator/ Clinical Director upon discovery.
 - D. Reporting injuries and illness to the Administrator/Clinical Director.
 - E. Obtaining the information necessary to perform tasks in a manner that prevents injury to themselves, patients and others.
2. The Administrator/Clinical Director and designated Safety Officer, as agents of the Quality Assurance Committee are responsible for:
 - A. Environment of Care development, implementation and monitoring.

- B. Report of Safety Surveillance and activities to the Quality Assurance Committee.
- C. Annual review of the Environment of Care policies and guidelines for objectives, scope, performance and effectiveness.

Maintenance and Supervision:

1. Comply with the NFPA 101®, Life Safety Code® (LSC) for maintaining and supervising the facility grounds, buildings and equipment.
2. Maintain equipment and utilities following a preventative maintenance schedule.
3. Maintain sufficient light in the parking and entrance areas to reduce the potential for falls and security concerns.
4. Maintain signs and emergency systems to meet the needs of the visual and hearing impaired.
5. Maintain smoke free environment.
6. Provide facility cleaning, maintenance, and inspection, following a schedule for daily, weekly, monthly, semi-annual and annual activities.
7. Construction and Renovation (Interim Life Safety Plan):
 - A. Meet the existing ambulatory health care occupancy health code requirements for construction or renovation.
 - B. Train staff in alternative safety processes including the use of new specialized equipment and space.
 - C. Train staff to compensate for changes in Life Safety Plan.
 - D. Provide increased facility safety monitoring with construction and renovation included reference to the NFPA 101®, Life Safety Code® (LSC).
 - E. Inspect and monitor components of Life Safety Plan weekly or more frequently if indicated.

Risk Assessment:

1. Provide risk assessment and hazard surveillance to evaluate the impact of the center building, grounds, equipment, occupants, and internal physical systems on patient, employee and public safety.
 - A. Assign a Safety Officer to maintain risk and hazard surveillance.
 - B. Record Hazard surveillance.
 - C. Report environmental hazard and safety surveillance to the Quality Assurance Committee. Provide follow-up to staff concerning safety issue recommendations.
2. Report and document patient, personnel or visitor injury, and occupational illness. Document

incidents on a Variance Report, Occurrence Report, or Incident Report.

- A. Investigate and evaluate each report for opportunities to improve performance.
- B. Include injuries and occupational illness in the report to the Quality Assurance Committee.

Product Safety Recalls:

1. Address a product safety recall upon notification.
 - A. Inventory and remove recalled product from possible use.
 - B. Notify affected medical staff and evaluate a substitute product.
 - C. Inventory patients who may have received a recalled medical device from implant logs or records.
 - D. Consult with the Medical Director and/or Quality Assurance Committee to evaluate the situation and determine an appropriate method for patient notification if an implanted medical device has been recalled. The medical director, as an agent of the Quality Assurance Committee reports the incident to the Medical Executive Committee.

Safety Education:

1. Provide Safety Education and Training at orientation and at least annually thereafter. Address general safety processes; area specific safety and job related hazards.
2. Provide Safety Guidelines in the General Orientation including:
 - A. Review of Safety Policies and Guidelines.
 - B. Body Mechanics.
 - C. Hazardous Materials Communication.
 - D. SDS/ Hazardous Waste.
 - E. Safety Risk / Responsibilities.
 - F. Equipment Safety/Operations Manuals.
 - G. Emergency Preparedness.
 - H. Utility Systems and Electrical Safety.
 - I. Infection Control/Exposure OSHA.
 - J. Reporting of Sentinel Events.

- K.** Variance, accidents/injuries, Security and Safety concerns.
 - L.** Fire and Life Safety.
 - M.** Safety Concerns.
 - N.** Security.
 - O.** OSHA.
- 3.** Include specific safety standards related to safe practices and the safe use, inspection, cleaning and maintenance of specialized equipment in the Department /Job Specific orientation.
 - 4.** Provide updates when new equipment is introduced.
 - 5.** Review General Safety Guidelines annually.

Reference:

Center for Medicare and Medicaid Services (July, 2011). Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery.

The Joint Commission. (2011) Accreditation Standards and Requirements for Ambulatory Surgery Centers

The Accreditation Association for Ambulatory Care. (2011). Accreditation Handbook.

PATIENT SAFETY PLAN

- I. The Patient Safety Committee of Quail Surgical and Pain Management Center has developed this Patient Safety Plan designed to ensure the health and safety of all patients treated at the Center. The Center Administrator and the Management Committee have designated the Operating Room Charge Nurse to serve as Patient Safety Officer. Activities involved in the Patient Safety Plan will be overseen and reported to the Patient Care Committee, the Clinical Review Committee and, ultimately, the Management Committee. The plan encompasses all aspects of patient care, including but not limited to:
 1. Building Security
 - a. Video surveillance to monitor access and the parking lot/grounds
 - b. Door security with coded building entry
 - c. Medical gases and vacuum pump lock-secured
 2. Medication Safety
 - a. Storage
 - b. Administration
 - c. Identification
 - d. Monitoring compliance
 3. Patient Transport
 - a. Gurneys, chairs, cribs, ambulating
 - b. Number of personnel
 4. Patient Positioning
 - a. Number of staff
 - b. Positioning devices
 - c. Recommended practices
 5. Infection Prevention
 - a. See Infection Control Plan
 6. Medical Equipment Safety
 - a. Preventative maintenance
 - b. Proper inservicing
 - c. Safety checks
 - d. Electrical equipment
 - e. Electrosurgical and Laser safety

- f. Radiology safety
 - g. Biomedical checks for new equipment and at scheduled intervals
- 7. Procedure Consents
 - a. Accuracy monitored
- 8. Emergency Management (Code, Fire, Transfer & Disaster Plans)
 - a. Medical emergency equipment, supplies, and medications available
 - b. Clinical alarm systems maintained
 - c. Staff competency maintained (education & drills)
 - d. Emergency power source maintained
 - e. Fire drills
 - f. See disaster plans
- 9. Patient Education
 - a. Pre-admissions instructions, testing, education
 - b. Post-operative discharge instructions
- 10. Protection of Patient Health Information
 - a. Privacy
 - b. IT information protection
 - c. "Red Flag" policy and staff training
- 11. Physical Plant Environment
 - a. Environmental controls monitored and maintained
 - b. Facility Safety Officer observations and reports
 - c. Consistent maintenance of the facility (floors, walls, etc)
- 12. Healthcare Personnel Competency
 - a. Orientation and training
 - b. Continuing education programs
 - c. Peer review, supervisory review, performance evaluations, competency reviews, credentialing criteria
- 13. Anesthesia Care
 - a. Equipment safety
 - b. Anesthesia gases
 - c. Competency/Peer review
- 14. Surgical Counts
 - a. Policy and procedure reviews
- 15. Sharps Handling
 - a. Safe sharps containers in patient care areas for disposal
 - b. Exposure Control Program

- II. The **Patient Safety Officer:**
 - a. Chairs the Patient Safety Committee
 - b. Maintains documents and minutes of the Patient Safety Committee
 - c. Supervises the reporting of Sentinel Events to the State and maintains documentation
 - d. Assists in the investigation and analysis of any alleged sentinel event
 - e. Coordinates and conducts a risk assessment for the identification of potential patient safety hazards at least annually
 - f. Works with the Patient Safety Committee to determine resolutions to safety hazards identified in the risk assessment
 - g. Reports all actions of the Patient Safety Officer to the Patient Safety Committee

- III. The **Patient Safety Committee** is established to review, evaluate and recommend measures and actions designed to improve the safety of all patients receiving care at the Surgery Center. Committee members will also evaluate the actions and reports of the Patient Safety Officer regarding sentinel events and near-misses.
 - a. Multidisciplinary membership to include:
 - 1. Patient Safety Officer
 - 2. Administrator
 - 3. Director of Nursing
 - 4. Medical Director
 - 5. PACU Charge Nurse
 - 6. RN Pharmaceutical coordinator/Contracted Pharmacist
 - 7. Facility Safety Officer
 - 8. Ad Hoc members as appropriate (Materials Manager, Sterile Processing Technician, Surgical Technologist, Radiology Technologist, Orderly)Members serve indefinitely.
 - b. The committee generally meets monthly or in response to events or occurrences.
 - c. The committee reports activities and makes recommendations to the Patient Care Committee, the Clinical Review Committee and the Management Committee

- IV. The patient safety plan and policies and procedures regarding patient safety are reviewed and approved annually by the Management Committee. These policies are based on state and local regulations and AORN's Recommended Practices. Policies are reviewed by staff upon hire and on a continual basis throughout the year.
- V. Patient safety is routinely included in Quality Improvement activities.
- VI. Surgery Center staff will initially review the Patient Safety Plan following approval of this plan by the Management Committee. All staff members will subsequently conduct an annual review of the plan. Signature sheets to indicate staff review will be maintained in the Inservice binder.
- VII. Medical staff and Allied Health personnel will be notified of the plan through written postings throughout the Center. Copies of the plan will be readily available for review.
- VIII. Compliance with the Patient Safety Plan will be monitored by Patient Safety Committee Members and reported to the Center Administration.

The Patient Safety Plan was reviewed and approved by the Management Committee on 1/22/19.



Quality, Patient Safety Plan

2019

This plan was created and revised by the Renown Health's Quality and Patient Safety Committee (QPSC). Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes. In addition, the plan is intended to encourage recognition, reporting, and acknowledgment of risks to patients, visitors, and employees as well as reduce medical/healthcare errors and/or preventable events. In addition this plan serves to direct the assessment of those services furnished directly by the organization or through contracted service, to identify opportunities to improve quality of those services and to implement appropriate corrective or improvement activities following the Plan, Do, Study, Act or PDSA model.

Quality and Patient Safety Plan

Contents

Commitment to Quality and Patient Safety	3
Mission, Vision, and Values	3
Scope and Purpose.....	3
Roles and Responsibilities.....	4
Components and Methods	6
Patient Safety Checklists and Patient Safety Policies	7
Approval of Quality and Patient Safety Plan	7

Commitment to Quality and Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, Renown Health's Quality and Patient Safety program promotes:

- Collaboration of leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Honest, open communication to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and values for each patient, family member, employee, and other healthcare providers.
- Responsibility for safety related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible patient outcomes.
- Incorporation of evidence-based safety practice guidelines to deliver high quality healthcare.
- Education of staff, physicians, new learners, patients and their families to promote patient safety and continuous quality improvement.

Scope and Purpose

This Quality and Patient Safety Plan applies across the entire Renown Health Acute Care Division.

All staff and physicians in Renown Health Acute Care Division are required to fully support and participate in this plan, and devote their expertise to the quality, patient safety, service and healthcare performance improvement process.

The purpose of this plan is to address safety, quality and service related concerns, challenges and to proactively identify opportunities to better serve patients and their families.

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

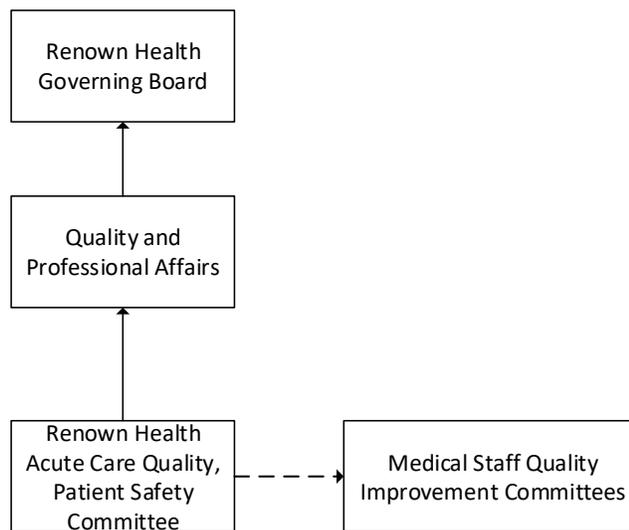
- Staff and physicians contributing their knowledge, vision, skill, and insight to improve the processes of quality, patient safety and service
- Promoting the concept that decisions are made based on data and facts
- A customer-focused approach including patients, families, and visitors

- System-based thinking
- Utilization of trained, expert staff and physicians.

Roles and Responsibilities

The Renown Health Acute Care Quality and Patient Safety Committee ensures that the Quality, Patient Safety Plan is promoted and executed successfully.

The Quality and Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), the Renown Health Acute Care Quality and Patient Safety Committee is comprised of:
 - The Renown Health Acute Care Infection Control Officer;
 - The Renown Health Acute Care Patient Safety Officer;
 - At least three providers of healthcare who treat patients, including at least one member of the medical, nursing and pharmaceutical staff;
 - One member of the executive or governing body;
 - A representative from Executive Leadership.

Quality and Patient Safety Committee Responsibilities (based in part on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy through event review and analysis when applicable.

- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
 - Number of sentinel events from previous calendar month
 - Number of hospital acquired infections that occurred in the organization
 - Corrective action plans for the sentinel events and infections.
- Review and evaluate the quality of measures carried out by the organization to improve the quality and safety of the care provided to patients.
- Review and evaluate the quality of measures carried out by the organization to prevent and control infections.
- Make recommendations to the executive or governing body of the organization to reduce the number and severity of sentinel events and infections.
- At least once each calendar quarter, report to the executive or governing body of the organization regarding:
 - (1) The number of sentinel events that occurred;
 - (2) The number and severity of infections that occurred; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
- A meeting agenda and minutes noting follow-up tasks will be kept.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the Renown Acute Care Quality and Patient Safety Committee.
- Supervise the reporting of all sentinel events alleged to have occurred, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred.
- Report to the QPSC directly or through his/her designee any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on in part on [NRS 439.873](#))

- Serve on the Renown Acute Care Quality and Patient Safety Committee.
- Monitor the occurrences of infections to determine the number and severity of infections.
- Report to the QPSC the number and severity of infections either directly or through his/her designee.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred.
- Carry out the provisions of the infection control program adopted pursuant in part to [NRS 439.865](#) and ensure compliance with the program.

Quality and Professional Affairs Committee of the Renown Health Board

- Provide vision and leadership that informs the safety processes, and develops and foster a safe learning and improving culture.
- Ensures the priorities of patient safety are aligned with the strategic priorities of the health system.

Components and Methods

The Renown Acute Care Quality and Patient Safety Committee uses data as a basis for recommendations for improvement.

Upon the identification of a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Root Cause Analysis

Renown Health Acute Care Division will use Root Cause Analysis (RCA) to determine the contributing factors and the underlying reasons for the deficiencies or failures involving sentinel events. Transformational Health Care principles and methods are incorporated into Renown’s RCA process.

An RCA is a process for identifying the root causes of process deviation or failure. It follows the principles of Just Culture by focusing on process reliability and failure rather than individual policy violation or failures.

Root Cause Analysis (RCA) Team Responsibilities

RCAs are conducted for all identified sentinel events and significant events/near misses involving complex process failure. Results of significant RCAs will be reported and monitored by the QPSC. RCA team responsibilities include:

- Conducting interviews in a fact-based, non-judgmental manner, analysis, investigation, and corrective action plan facilitation
- Coordination and participation in the RCA meetings and discussions
- Communicating in an honest and open manner regarding data and facts to with the team members and their supervisors/leaders
- Incorporating the principles of Just Culture in the RCA process.

Data Collection and Reporting

Data drives efforts to improve quality, safety and service. Renown Health uses Midas+ and other databases for tracking sentinel events, healthcare infections, patient grievances and other patient safety related data.

External data sources are also utilized for improvement efforts. These include but are not limited to:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention

- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

Patient Safety Checklists and Patient Safety Policies

Another process used to improve quality, safety and service is the development of patient safety checklists and patient safety policies. Renown Acute Care anticipates that these checklists are utilized by:

- Providers of healthcare who provide treatment to patients at the organization;
- Other personnel who provide treatment or assistance to patients;
- Employees who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the organization; and
- Persons with whom the organization enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Renown Health Acute Care Quality and Patient Safety Committee reviews and approves annually patient safety checklists based on policy.

The Quality and Patient Safety Plan includes an infection control program that carries out the infection control policy. This program exists as individual and separate documents and consists of:

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

The Renown Health Infection Prevention Plan and Program is established and approved by the Renown Health Infection Control Committee. Regular reports and updates regarding the Infection Prevention Program are provided to the Patient Safety Committee.

Approval of the Quality and Patient Safety Plan

The Renown Health Quality and Patient Safety Plan is reviewed and updated annually and is approved by the Quality and Professional Affairs Committee of the Renown Health Board.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current Quality and Patient Safety plan must be submitted to the Division of Public and Behavioral Health.

Attachment A

Carson Tahoe Regional Medical Center 2019 Checklist Inventory			
Checklist Title		Checklist Category	Department
1	HERT Team Leader Checklist	Other Safety	Emergency Mgt.
2	HERT Activation Checklist	Other Safety	Emergency Mgt.
3	HERT Ambulatory and Non-Ambulatory Set-Up Checklist	Other Safety	Emergency Mgt.
4	HERT Dirty Water Set-up Checklist	Other Safety	Emergency Mgt.
5	HERT Triage/Morgue Set-up Checklist	Other Safety	Emergency Mgt.
6	HERT Tent Set-up Checklist	Other Safety	Emergency Mgt.
7	HERT Receiving Checklist	Other Safety	Emergency Mgt.
8	217 Telemetry, Medical/Oncology & Pharmacy Swing	Environment	Housekeeping
9	304 Projects/Floor Care	Environment	Housekeeping
10	Form 100 Lead/Admin	Environment	Housekeeping
11	Form 101 Telemetry	Environment	Housekeeping
12	Form 102 Medical Oncology A & Pharmacy	Environment	Housekeeping
13	Form 103 Medical Oncology B Therapy Gym	Environment	Housekeeping
14	Form 104 OB/Peds	Environment	Housekeeping
15	Form 105 Surgical/Orthopedics	Environment	Housekeeping
16	Form 106 ICU/CVU	Environment	Housekeeping
17	Form 107 ER/OBS/Fast Track Days	Environment	Housekeeping
18	Form 108 OR Days	Environment	Housekeeping
19	Form 109 Cath Lab/Outpatient Days	Environment	Housekeeping
20	Form 110 Public Area	Environment	Housekeeping
21	Form 111 Waste Management Days	Environment	Housekeeping
22	Form 112 BHS Check Sheet	Environment	Housekeeping
23	Form 113 BHS 'C' Unit	Environment	Housekeeping
24	Form 114 Floor Care	Environment	Housekeeping
25	Form 200 Lead	Environment	Housekeeping
26	Form 202 Tele/OB Swing	Environment	Housekeeping
27	Form 203 Swing Surgical/Orthopedics, CVU and ICU	Environment	Housekeeping
28	Form 204 ICU/CVU Swing	Environment	Housekeeping
29	Form 205 ER/OBS Fast Track Swing	Environment	Housekeeping
30	Form 206 OR Swing	Environment	Housekeeping
31	Form 207 Cath Lab/X-Ray Outpatient	Environment	Housekeeping
32	Form 208 Waste Management Swing	Environment	Housekeeping
33	Form 209 SMC First Floor	Environment	Housekeeping
34	Form 210 Cancer/Merriner	Environment	Housekeeping
35	Form 211 Minden Checklist	Environment	Housekeeping
36	Form 212 Mica Surgery/Pain Clinic	Environment	Housekeeping
37	Form 213 Projects/Floor Care	Environment	Housekeeping
38	Form 214 Projects/Floor Care	Environment	Housekeeping
39	Form 215 Projects/Floor Care	Environment	Housekeeping
40	Form 216 Lab/Office Swing	Environment	Housekeeping
41	Form 217 Telemetry, Med Oncology A and Phm Swing	Environment	Housekeeping
42	Form 301 ER/OBS/Fast Track	Environment	Housekeeping

Attachment A

Carson Tahoe Regional Medical Center 2019 Checklist Inventory			
	Checklist Title	Checklist Category	Department
43	Form 302 OR	Environment	Housekeeping
44	Form 303 Basement/Discharges/OR	Environment	Housekeeping
45	Form 304 Projects/Floor Care	Environment	Housekeeping
46	Quality Assurance Checklist	Environment	Housekeeping
47	Pediatric Unit Department Checklist	Environment	PEDS
48	Discharge Checklist for Patients	Discharge	BHS
49	Discharge Checklist for Nursing	Discharge	BHS
50	Admission Checklist Nurse and Tech/Unit Clerk	Other Safety	BHS
51	AMA Intervention Checklist	Other Safety	BHS
52	Shift Checklist for Nursing Staff	Other Safety	BHS
53	Psychosocial Treatment Plan Tracking Form	Treatment	BHS
54	Sharp Contraband Tracking Form	Treatment	BHS
55	Fire Drill Participation	Environment	House wide- Security
56	Fire Report	Environment	Security
57	Fire Watch Form	Environment	Security
58	Life (Fire) Safety Inspection/Business Occupancy	Environment	Security
59	Life (Fire) Safety Inspection/Healthcare Occupancy	Environment	Security
60	Patient Observation Checklist	Other Safety	Security
61	Adult Crash Cart Checklist	Other Safety	House wide
62	Newborn Nursery Crash Cart Checklist	Other Safety	House wide
63	OB Hemorrhage Cart Checklist	Other Safety	House wide
64	Pediatric Crash Cart Checklist	Other Safety	House wide
65	OB Recovery Room Red Cart	Other Safety	House wide
66	OB OR Checklist	Other Safety	Women's/Children
67	3M Steam Flash Sterilization Log	Other Safety	House wide
68	AED Checklist	Other Safety	House wide
69	Breast Milk Refrigerator Temperature Log	Other Safety	Women's/Children
70	Refrigerator/Freezer Temperature Record	Other Safety	House wide
71	List and Process Monitor Documentation System	Other Safety	GBI
72	NV State Immunization Program Temperature Log	Other Safety	Women's/Children
73	Nursery Blanket Warmer Temperature Log	Other Safety	Women's/Children
74	OB/RR Blanket Warmer Temperature Log Top Compartment	Other Safety	House wide
75	Ticket to Ride	Other Safety	House wide
76	Central Line Associated Blood Stream Infection (CLABSI) and Catheter Associated Urinary Tract Infection (CAUTI) surveillance	Other Safety	Infection Control
77	CAUTI Bundle Audit Data Collection	Other Safety	Infection Control
78	Hand Hygiene Compliance Monitoring	Other Safety	Infection Control
79	Infection Control Risk Assessment	Other Safety	Infection Control
80	Emergency Equipment Checklist	Other Safety	ICU
81	Urgent Heart Chart Daily Checklist	Other Safety	ICU

Attachment A

Carson Tahoe Regional Medical Center 2019 Checklist Inventory			
	Checklist Title	Checklist Category	Department
82	Chemotherapy Administration Checklist	Other Safety	Medical Oncology
83	Pre-Op/Circ/PACU Chart Deficiency Checklist	Treatment	Surgical Areas
84	Hand-off Communication Sheet Pre-Op/OR/PACU	Treatment	Surgical Areas
85	Surgical Checklist	Treatment	Surgical Areas
86	Universal Protocol Checklist/Hand-off Communication	Treatment	Surgical Areas (not SSH)
87	Universal Protocol Checklist for Injection Procedures	Treatment	Surgical Areas (not SSH)
88	Pre-op/Procedural Checklist	Other Safety	Surgical Areas (not SSH)
89	Ventilator Calibration Checklist	Other Safety	Respiratory
90	BHS Unit Safety Rounds Worksheet	Other Safety	House wide
91	Carson Tahoe Emergency Department Triage Protocol	Other Safety	Emergency Dept.
92	Carson Tahoe Emergency Department Stroke Protocol (MD Guidelines)	Other Safety	Emergency Dept.
93	Magnetic Resonance Imaging (MRI) History and Assessment	Treatment	Medical Imaging
94	MRI Invasive Procedure Checklist	Treatment	Medical Imaging
95	Non-Ionic and/or Ionic Contrast Consent Form	Treatment	Medical Imaging
96	Pre-Catheterization/Vascular Lab Checklist	Treatment	Catheterization Lab
97	Patient Room Safety Inspection	Other Safety	House wide
98	Pre-op Education	Treatment	Mica Surgery



Current Status: Active

PolicyStat ID: 5871666



Effective Date: 05/2015
Reviewed Date: 01/2019
Revision Date: 01/2018
Next Review: 01/2020
Owner: Susan Wallis: Corporate Director of HIM
Policy Area: A. Patient Rights and Organizational Ethics
References:
Applicability: Acadiana Management Group
 AMG Physical Rehabilitation Hospital
 Lafayette Physical Rehabilitation Hospital
 North Alabama Specialty Hospital

A.1.26 Patient Safety Plan - LAS VEGAS ONLY

POLICY:

This is an internal safety plan designed to assist in the improvement of the health and safety of patients treated at AMG Specialty Hospital Las Vegas. The goal of the plan is to reduce and eliminate any potentially unsafe practices thereby promoting an environment of safety for our patients.

To notify patients; who are involved when a sentinel event occurs or of any infections present on admission and/or if they have acquired infections at AMG Specialty Hospital Las Vegas; pursuant to Nevada statutes. The plan is submitted to and approved by the governing board of AMG Specialty Hospital Las Vegas as required in NRS 439.865.

AMG Specialty Hospital Las Vegas's health care providers were notified of the initial plan and are able to freely access the plan for any completed updates to facilitate compliance with NRS 439.800-890. (Notification 10/09, 7/11, 2/11, 2-12, 2-13, 10-13, 2-14)

AMG Specialty Hospital Las Vegas (AMG) will maintain a Patient Safety Plan that complies with the statutes and rules pursuant with NRS 439.800-890 and NAC 439.900 to .920 inclusive of 2010 Regulations.

Established a Patient Safety Committee, pursuant to NRS439.875, that:

- Meets monthly
- Is Chaired by the Patient Safety Officer
- Includes the Infection Control Officer
- Contains at least three health care providers
- Includes one member from Pharmacy
- Includes one member from medical staff
- Includes one member from nursing
- Includes one member of the executive or governing body.

AMG Specialty Hospital Las Vegas has designated a Patient Safety Officer (PSO) who:

- Serves on the Patient Safety Committee, (PSC)

- Reports to the PSC Monthly, Quarterly and Yearly. Supervises the reporting of all sentinel events with active participation of the PSC. (NRS439.835)
- Takes action he/she determines necessary to ensure the safety of patients as a result of any investigation involving a safety risk or sentinel event that has occurred at AMG Specialty Hospital Las Vegas.
- Reports any actions taken to the Patient Safety Committee, the state reporting agencies and communicates with the patient as per NRS439.855 (2).0.

AMG Specialty Hospital Las Vegas has designated the CCO who functions in the role of Infection Control Preventionist and as the Infection Control Officer (ICO) +who:

- Serves on the PSC
- Monitors the occurrences of infections to determine the number and severity of infections.
- Reports to the PSC concerning the number and severity all infections at AMG.
- Takes such action as he/she determines is necessary to prevent and control infections alleged to have occurred at AMG.
- The Infection Control Officer or staff she designates notifies patients who have been admitted with POA, Present on Admission Infection(s), or who develop an infection at the facility (HAI), will be notified within 5 days of the Infection Control Officer's positive identification of the infection(s) as required by the statute.
- Reports Monthly, Quarterly and Yearly to the PSC.
- Shall carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.
- AMG Specialty Hospital Las Vegas has less than 175 beds and therefore, will comply with 439 SEC 3. 4; AMG Specialty Hospital Las Vegas complies with this regulation and will:
- Maintain the records of completion of the required training in the employee file.
- Maintain periodic reviews by a certified infection preventionist consultant
- AMG designates a qualified backup person, who has received the required training, to carry out the duties of the Infection Control Officer, when he/she is absent per statute.

Patient Safety Committee:

- Will receive reports from the Patient Safety Officer and Infection Control Officer pursuant to NRS 439.870
- Will review and evaluate compliance with notification of patients who have been admitted with Present on Admission infection (POA) or developed an infection at the facility HAI, as required by the statute.
- Will post in publicly accessible areas and provide, to patients, information on reporting facility-acquired infections, including the contact information to the Health Division.
- The information provided to each patient includes all statutory requirements pursuant to 439.870 paragraph (a) of subsection.
- Has established pursuant to NRS 439.875 patient safety checklists and patient safety policies for use by: (The patient safety checklists adopted, pursuant to NRS 439.875 AB 280 subsection 1, follow protocols to improve the health outcomes of patients at AMG Specialty Hospital Las Vegas).
 - a. Providers of health care who provide treatment and/or care;
 - b. Other personnel who provide treatment or assistance to patients;
 - c. Employees of the medical facility who do not provide treatment but whose duties affect the health or welfare of the patients including janitors.
 - d. Persons with whom the medical facility enters into a contract to provide treatment or services which may affect the health or welfare of patients at the facility.
- Has a policy for appropriately identifying patients before providing care. Located in Section K care of patients in the AMG Policy and Procedure Manual.

- Shall monitor and document the effectiveness of the patient identification policy and the use of patient safety checklists adopted pursuant to NRS 439.875.
 - a. Will submit a report to the Director of the Legislative Counsel Bureau on or before July 1 of each year, pursuant to NRS 439.875.
- Shall evaluate the reports of sentinel events alleged to have occurred, submitted by Patient Safety Officer.
- Review and evaluate the quality measures carried out to improve the safety of patients who receive treatment at AMG Specialty Hospital Las Vegas.
- Make recommendations to the executive or governing body regarding any sentinel events for the previous calendar quarter and the plans to reduce the number and severity of events at AMG Specialty Hospital Las Vegas.
- All records are considered confidential and protected from discovery, as described in NRS 439.265 and in NAC 439 regulation R044-10 Sec. 6, 5. and NRS 239.0115.

PATIENT SAFETY GOALS:

Selected recommendations will be monitored on a routine basis to evaluate AMG Specialty Hospital Las Vegas's effectiveness in implementation and compliance with National Patient Safety Goals.

Goals are as follow:

- Improve the accuracy of patient identification
- Increase the effectiveness of communication among caregivers
- Improve the safety of giving medications
- Reduce the risks of health care infections
- Improve the response to alarms in the care environment.
- Improve the care of patients who require indwelling catheters and tubes.
- Use bundles to improve care patterns
- Accurately and completely reconcile medications across the care continuum
- Reduce the risk of patient harm resulting from falls
- Encourage patients active involvement in their care as a patient safety strategy
- AMG Specialty Hospital Las Vegas will identify risks inherent to its patient population
- Improve recognition and response to changes in condition

DISCLOSURE OF UNANTICIPATED OUTCOMES:

AMG Specialty Hospital Las Vegas will follow the policy "Effective Patient Communication" in relating to the patient and when appropriate the patient's family about outcomes of care that the patient (or family) must be knowledgeable about in order to participate in current and future decisions affecting the patient's care and unanticipated outcomes of care.

Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job related aspects of patient safety including the methodology to report medical/healthcare errors and on the provision of an interdisciplinary approach to patient care for the optimal delivery of health care.

Unanticipated outcomes, including sentinel events, will be reported internally and externally as per AMG Specialty Hospital Las Vegas's policies. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and regulations. NAC 439.900-.920 and NRS 439.800 to .890, 2013

The Patient Safety Committee will report to AMG Specialty Hospital Las Vegas's Committee of The Whole (COW) meeting regarding any Performance Improvement (PI) or plans implemented subsequent to patient safety issues or sentinel events.

Upon identification of an unexpected occurrence the patient care provider will immediately:

- Perform the necessary healthcare interventions to protect and support the patient's clinical condition.
- Perform necessary healthcare interventions to reduce the potential risk to other patients.
- Contact the patient's physician to report the unexpected occurrence.
- Report the unexpected occurrence to their immediate supervisor and complete an event report.
- The Supervisor will immediately call their director and report the occurrence.
- Submit the event report to the CCO or designee.
- Forwards to Risk Management.
- If a PI team is initiated to assess the unexpected occurrence the care provider will make them self available to the team.

PATIENT SAFETY PLAN:

The scope of the Patient Safety Plan encompasses the patient population, visitors and staff (including medical staff).

The Plan addresses the maintenance and improvement in patient safety in every department throughout AMG. Areas the plan covers are:

- No harm errors: those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome but do not result in a physical or psychological negative outcome, or the potential for a negative outcome for the patient.
- Medication errors
- Infection Control Program:
 1. The Infection Control Program is contained in the AMG Policy and Procedure Manual Sec. R Surveillance, Prevention and Control of Infection and follows the Centers for Disease Control, CDC, National Health Safety Network, NHSN, (nationally recognized infection control guidelines).
 2. Was developed under the direction of a certified infection preventionist (CIP), and as a less than 175 bed facility does not require a CIP, but the ICO has passed an infection preventionist course and keeps yearly training up to date with at least 4 CEU's of infection prevention related continuing education. NAC 279, SB 339
 3. Includes a "backup" person as required per statute and addressed under the CCO section of this document; keeps yearly training up to date with at least 4 CEU's of infection prevention related continuing education.
- Adverse drug reactions
- Restraints
- Falls
- Hazardous conditions; any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel events "Sentinel Event means an event included in Appendix A of "Serious Reportable Events in Healthcare-2011 Update: A Consensus Report", published by the National Quality Forum or, if revised, the most current version of the list of serious reportable events, published by the National Quality Forum.

If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist. (NRS 439.830)

- The Sentinel Events Policy can be found in the Leadership Manual
- For reporting sentinel events refer to the Sentinel Events Policy.

The Patient Safety Plan will place an emphasis on important AMG Specialty Hospital Las Vegas and patient care functions:

- Patient rights
- Assessment of patients
- Care of patients
- Patient/Family education
- Continuum of care
- Infection Control – Surveillance, control and prevention of infection
- Leadership
- Organization Performance Improvement
- Information management
- Human Resources management
- National Patient Safety Goals
- Life Safety
- Record of Care, Treatment and Services.

METHODOLOGY:

The Patient Safety Committee:

- Is responsible for the oversight of the Patient Safety Plan.
- Meets monthly and receives a report in regards to the patient safety issues that occurred during the past calendar month.
- Includes by statute the Patient Safety Officer, the Infection Control Officer, at least three healthcare members; one member of the medical staff, pharmaceutical and nursing staff and a member of the executive or governing body attend each meeting.
- Is a sub-committee of the General Safety Committee
- Will review internal and external data, PI activities, sentinel events, infection control.
- Will direct updates of the policies and procedures necessary secondary to sentinel event occurrence, and review those policies at the first meeting post update.
- Will facilitate training as needed post sentinel event.
- Will review the status of the reporting progress to the Health Division, the root cause analysis team appointments and the performance of the Patient Safety Officer in completing the necessary tasks.
- Will review and evaluate the quality measures carried out to improve the safety of patients receiving treatment at AMG.
- Will review and evaluate the quality measures carried out to prevent and control infections at AMG.
- Will review and evaluate the number of patients notified of any infections acquired at AMG per statute.
- Members of the sub-committee may or may not attend the full safety meeting.

The Patient Safety Officer and Infection Control Officer:

- Will be responsible for the administration of the plan.
- Will submit a monthly report to the PSC

- Will prepare, quarterly, a report for the PSC that covers any patient safety related issues that have occurred in the preceding 3 months.
- Will submit an annual report to the committee covering the past year.

NEW PROCESS DESIGN:

When the Patient Safety Committee

- Designs a new process, function, or service, it will utilize a standard document format for planning, implementing and evaluating the design and will consult with the administration team to facilitate the process and ensure all aspects and expectations are clear.
- Will take in to account the Mission Statement and Values of AMG Specialty Hospital Las Vegas, the needs of patients, staff and others when determining whether the program is clinically sound and current.
- The process foundation will be evidence based.
- Will consult a variety of information sources and incorporate available information from within the organization and other organizations about potential risks to patient safety, including the occurrence of sentinel events, in order to minimize risks to patients affected by the new/redesigned process, function or service.
- Will recommend the scale of the pilot program and monitor progress to determine whether the proposed design/redesign is an improvement.

REPORTING SAFETY AND QUALITY CONCERNS:

- An effective Patient Safety Plan cannot exist without optimal reporting of unexpected occurrences.
- All reporting will be received in a non-punitive manner in its management of errors and occurrences.
- All staff should feel free to report unexpected occurrences without fear of reprisals.
- Errors occur due to a breakdown of systems and processes and require event reports and full notification of the medical and administrative staff.
- AMG Specialty Hospital Las Vegas will use reporting to place the focus on improving systems and processes. The focus will be placed on remedial actions to assist rather than punish staff members. Any employee who has concerns about the safety and/or quality of care provided at AMG Specialty Hospital Las Vegas is encouraged to report their concerns to:
 - Their Supervisor
 - CCO, Department Directors
 - The Patient Safety Officer
 - Safety Officer
 - Infection Control Officer
 - CEO

Any individual in any department who identifies a potential safety issue will immediately notify his/her supervisor.

- The supervisor or director of the department will prepare a report for the Patient Safety Officer and potentially initiate a PI review to assess relevance of initiating a PI team.
- No harm errors require completion of an event report, all normal notifications, and a review by the PSC
- Mild to moderate adverse outcomes require immediate clinical interventions, notification of the patient's physician, response to related physician orders, completion of an event report and all notifications. The staff then documents the facts in the medical record and an event report is submitted to Action Cue and

the Patient Safety Officer reviews for submittal to the PSC.

- Adverse Drug Reactions: require staff to perform any clinical interventions to support and protect the patient, notification of the physician responsible for the patient, implementation of any subsequent orders, notification of the Pharmacy and all other required notifications as per policy, documentation of the facts in the medical record and on an event report. (Medication errors that are No Harm, moderate adverse outcomes or adverse reactions must be reported to the CCO and Pharmacy). The director of Quality will review the event report and if a sentinel event is suspected the Patient Safety Officer will be notified for further communication with the Patient Safety Committee.
- Hazardous Condition/Patient Safety issue: as appropriate, and if possible, staff will contain any hazardous condition or patient safety issue. Staff identifying a hazardous condition or a potential patient safety issue will immediately fill out an event report and complete all notifications as per policy.
- Event reports that relate to patient safety will be reported by the supervisor to the Patient Safety Officer. PI will be done as appropriate. The PSC will review.
- Sentinel Event: staff will perform any necessary clinical assessments and interventions to support and protect the patient, notify the physician responsible for the patient, carrying out any orders subsequent to the event and then follow the Sentinel Events Policy and Procedure. The Patient Safety Officer will notify The Patient Safety Committee (PSC) who will review and respond to the potential sentinel event at the nearest meeting date possible. Any reporting to the SE registry is per statutes and AMG Specialty Hospital Las Vegas sentinel events policy.
- AMG Specialty Hospital Las Vegas Policies such as the Sentinel Event Policy will determine the organizational response to unexpected occurrences. All sentinel events will have a root cause analysis conducted as pursuant to NAC 439. The determination of the Patient Safety Committee members, based on internal and external data analysis and prioritizing of patient safety will determine if further remedial action necessary for identified occurrences, proactive occurrence reduction activities, or if a FEMA (Failure Mode Effects Analysis) will be performed. External notifications will be carried out as outlined per NAC 439.900 to .920, and NRS 439.800 to .890.

EXCEPTIONS TO NON PUNITIVE REPORTING:

- All responses to unexpected occurrences will be investigated and any disciplinary action will be subsequent to that investigation;
- In the event that staff competency is the root cause for a pattern of errors; AMG Specialty Hospital Las Vegas management will make every reasonable effort to ensure staff can reliably deliver safe care. If it becomes clear that a staff member cannot practice in a reliably safe manner, in spite of education and counseling, this situation will be treated as a staff competency issue through disciplinary procedures.
- When staff knowingly performs intentional acts with intent to harm or deceive a patient possible disciplinary action may ensue.

SENTINEL EVENTS:

The policy regarding sentinel events can be found in the leadership manual and includes but is not limited to the following:

- Reporting process, procedure for reporting and the time line for compliance.
- Professional or emotional support for staff involved in a sentinel event.
- Root Cause Analysis and/or action plan processes
- Staff Members role in the process resolution
- Availability of training or personal consultation for any staff involved.
- Feedback from patients, family and staff.

- Staff opinions, needs and perceptions of risks to patients, and requests/ suggestions for improving patient safety.
- Disclosure to the patient/patient family is outlined in the Effective Patient Communication Policy and the Sentinel Event Policy and Procedure and completed as per the statutory requirements (within 7 days). This disclosure is an important patient right.
- Staff will educate patients and families about their role in facilitating safe delivery of care.
- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job related aspects of patient safety including the need and method to report unexpected occurrences and the provision of an interdisciplinary approach to patient care to facilitate the optimal delivery of health care.
- Unexpected occurrences, including sentinel events, will be reported internally and externally, per AMG Specialty Hospital Las Vegas Policy, NAC 439.900 to .920, Reg. and NRS 439.800 to .890. External reporting will be in accordance with all state, federal and regulatory body rules, laws and requirements.
- Patient Safety Reports will be submitted by the Patient Safety Officer to the Patient Safety Committee for review and further for medical, executive and governing body review.
- A quarterly Patient Safety Report from the Patient Safety Officer/Infection Control Officer/Committee will be presented to the Committee of the Whole (COW) including unexpected occurrences, Sentinel events and the actions taken to improve patient safety, reduce patient risks, and in response to actual occurrences and re activity.
- The Patient Safety Committee will on a yearly basis evaluate the effectiveness of the Patient Safety Plan; review the Patient Safety Checklists, review policies related to patient safety and update as needed and changes will be present to the MEC for approval as with all Policies and Procedures.
- Quarterly the Patient Safety Committee will report, to the governing body, on the number of sentinel events; as well as the number and severity of infections that occurred at AMG during the preceding calendar quarter.
- On or before July 1 each year, the PSC will submit a report to the Legislative Counsel Bureau that includes information regarding the past years development, revision and usage of the patient safety checklists, patient safety policies and a summary of the annual review. (Pursuant to NRS 439.875.)

[AMG Healthcare Failure Modes and Effects Analysis-FMEA- Intro.doc](#)
[ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE.docx](#)

Attachments:

Approval Signatures

Approver	Date
Name Here: Chief Executive Officer	01/2019
Name Here: Corporate Director of HIM	01/2019
Name Here: Corporate Chief Clinical Officer	01/2019

Applicability

AMG Physical Rehabilitation Hospital, Acadiana Management Group, Lafayette Physical Rehabilitation Hospital,

COPY

**Dignity Health – St. Rose Dominican
Siena Campus**

PATIENT SAFETY/RISK MANAGEMENT PLAN

DATE: 01/2019



This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program
St. Rose Dominican – Siena Campus**

3001 St. Rose Parkway
Henderson, NV 89052
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Contents

Commitment to Patient Safety.....	3
Mission, Vision, and Values	3
Scope and Purpose.....	3
Roles and Responsibilities	4
Roles and Responsibilities	4
Objectives and Goals of the Patient Safety/Risk Management Plan	10
Components and Methods	11
Root Cause Analysis	14
Model for Improvement	15
Data Collection and Reporting.....	15
Ongoing Reporting and Review.....	15
Assessment of the Quality and Patient Safety Plan	16
Patient Safety Checklists and Patient Safety Policies	16
Approval of Patient Safety Plan.....	17
References	18

Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, Dignity Health – St. Rose Dominican, Siena Campus' Patient Safety/Risk Management program promotes:

- Honest, open collaboration and partnership of hospital leadership, medical staff, patients and their families, the community and other healthcare providers to deliver compassionate, high-quality, affordable healthcare.
- Promote justice and respect for those we serve.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility and accountability for every healthcare related decision and action.
- A focus on excellence, teamwork and innovation through continuous learning, improvement in system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The Patient Safety/Risk Management Program at St. Rose Dominican is an organization-wide/campus specific strategy that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety/Risk Management Program at Siena Campus supports and encourages the active participation of each person in order to be an effective program. When processes, functions or services are designed or redesigned, information internal and external to the campus and/or organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or services.

The purpose of this plan is to establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program Plan designed to promote and improve patient safety at Dignity Health – St. Rose Dominican, Siena Campus, by working to prevent medical/healthcare adverse events and reducing risk to patients and visitors.

Undesirable facility specific and system patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns or trends vary significantly and undesirably from those expected including significant near misses;
- Performance varies significantly and undesirable from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
 - Hospital acquired infections
 - Medication events, to include delays in administration
 - Adverse drug events
 - Transfusion reactions
 - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

Roles and Responsibilities

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

The Patient Safety Committee Organization

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;

- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

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

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Siena Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

- (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- See Quality Department's Performance Improvement Plan

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

The Manager of Risk Services has been designated the Patient Safety Officer for the Siena Campus and as such, has the administrative responsibility for the program specific responsibilities including:

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Day to day responsibility for the Patient Safety/Risk Management Program at Siena Campus.
- Maintenance of related data collected, trended and analyzed at each campus.
- Routine reporting to leadership and QCAC on campus specific trended data and actions taken to improve the quality and safety of patient care.
- Working with QCAC to achieve the goals of the Patient Safety/Risk Management Program.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.

- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporates the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Identify RCA participants and coordinate a time, date and location of RCA meeting.
- Inform RCA participants of the sentinel event process.
- Explain confidential nature of RCA.
- Explain Just Culture and its application.
- Review event using medical record and any other pertinent materials in preparation for the RCA.
- Provide RCA members access to relevant best practice/research documents/statutes and other literature to include hospital Policy and Procedure documents for reference.
- Conduct RCA in a manner consistent with Just Culture, using principles of human factors, systems theory, etc.

Executive or Governing Body Staff Responsibilities

Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.

Leadership

The Dignity Health St. Rose Dominican Board and campus Senior Leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety/Risk Management Program. These responsibilities are campus specific and include the following:

- Foster an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.

- Establish a culture in which communication flows freely regardless of authority gradient.
- Ensure that a define, on-going, proactive program for identifying risks to patient safety and reducing medical/healthcare adverse events is fully implemented and includes responses to actual and potential events;
- Ensure that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Provide for mechanisms to measure, analyze and manage variation in the performance of defined processes that affect patient safety;
- Allocate adequate resources, including personnel, time, information systems data associated with reducing risk and improving patient safety, and
- Active participation in the California Hospital Patient Safety Organization (CHPSO).

Physicians

Physicians are responsible, as participants in the Patient Safety/Risk Management Program for reporting events or near misses at each campus, and participating on focus teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (LIP) or comparable designee shall clearly explain these outcomes to the patient, and when appropriate, the family. (See Disclosure Policy)

Patients/Families/Visitors

Patients, families and patient representatives via written communication are encouraged to be active participants in their care and as such are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to the patient's health;
- Reporting their patient and outcome of treatment of that pain
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner, and
- Asking questions when they do not understand what they have been told about the patient's care, infection control, safety precautions and programs or what they are expected to do etc.

Patients and families/patient representatives/visitors will be provided with educational materials explaining these expectations and their role in reducing risk exposure and improving patient safety at the time of admission and throughout the patient stay utilizing various delivery methods including pamphlets, television and verbal communication. Some patients may also be included in the development process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

Hospital Departments and Staff

Siena staff are key to promoting, identifying, and implementing activities to reduce risk and improve patient safety. Some of the activities include:

- Active participation in the activities to improve patient safety and the quality of healthcare delivered;

- Adherence to Infection prevention measures, the Joint Commission National Patient Safety Goals and other patient safety initiatives;
- Participation in education activities and process implementations;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among caregivers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in information needs assessment, staff surveys, and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all events and process variances (harm or no harm) even if they do not reach the patient (near miss).

The Patient Safety Committee

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Siena Campus and includes multidisciplinary team members which have oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow up on patient safety related trends, analysis results, changes in processes, policies and other areas to make as a result of identified needs.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.
- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Patient Safety/Risk Management Plan

Goal	Plan	Due Date
Risk Assessments	1. Patient Safety/Risk Management to perform monthly risk assessments and report to PSC. 2. Infection Prevention to report to PSC findings of Risk Assessments.	Monthly PSC
FMEA	PSC to ensure one FMEA is conducted by Risk Management in CY 2019.	December 2019
Checklists	PSC will receive all new and renewed checklists used that impact patient safety whether directly or indirectly.	Monthly and ongoing
National Patient Safety Goals	PSC will support the posting of NPSGs throughout the hospital for staff reference.	Department leaders
Root Cause Analysis	RCAs will be conducted by Risk and Quality Management as soon as possible/practical after an event per Dignity Health policy	Ongoing
Manager orientation	Quality Risk Services will review/update Manager orientation.	March 31, 2019
Grievance Management	Grievances will be reviewed by the Grievance Committee to ensure compliance with CMS CoPs.	Quarterly and ongoing.
Staff and physician education	Patient Safety education will occur in various forms (e.g. Huddles, Department Meetings, Leadership Meetings, Posters) throughout the year.	Ongoing

Components and Methods

Proactive Risk Assessment Activities

The Patient Safety/Risk Management Department, in collaboration with the various facility committees including Infection Prevention, Quality Council and leadership will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk Assessment activities will include, but not be limited to the following:

- Patient Safety Risk Assessment evaluating known high risk processes/procedures that have associated risks,
- Review employee survey results to identify safety concerns,
- On-going risk assessments based on internal and external data, including sentinel event alerts,
- Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.
- Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of Siena campus,
- Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.
- Patient Satisfaction surveys will include a question determining how the patient/family thinks the individual facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.
- Infection Prevention Surveillance Program.
- Additional staff surveys may be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety, as well as the staff's willingness to report medical/healthcare events.

Event Reporting

Siena actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration and evaluation activities. As provided under the CHPSO (42 Code of Federal Regulations (CFR) Part 3 Section 3.20) the event report is considered a Patient Safety Work Product and as such is privileged and shall not be (1) subject to subpoena; (2) subject to discovery; (3) subject to disclosure and (4) admitted into evidence-provided such information is not subject to disclosure in certain criminal proceedings as described in regulation. (See Event Reporting and Management Policy).

- A. When an unplanned event/process variance occurs, the patient care provider will do the following:
 - a. Perform the necessary healthcare interventions to support the patient's clinical condition.
 - b. Perform the necessary interventions to contain the risks to others.
 - c. Notify the patient's attending physician.
 - d. Preserve any information related to the event including physical evidence. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Report and in the patients' medical record.
 - e. Notify immediate supervisor of the event.
 - f. Submit electronically an Event Report form or handwritten Event Report form to Risk Management/Patient Safety Services.
- B. Identification of potential unsafe condition that may affect patient safety:

- a. Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
- b. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention

- A. Patient safety related event reporting data within the scope of the Patient Safety Program and risk assessment results will be aggregated and presented routinely to various committees including but not limited to Medical Executive Committee (MEC), Medication Safety, Quality Council and Environment of Care for analysis and action. Based on analysis of this data and any actual or potential reviews, sentinel events and other internal and external data including TJC Sentinel Event Alerts, Dignity Health Shared Learnings, CHPSO trends, current literature, proactive action plan will be developed to include the following:
 - a. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
 - b. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
 - c. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
 - d. Redesign of the process and /or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
 - e. Test and implement the redesign process;
 - f. Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and
 - g. Implementation of a strategy for maintaining the effectiveness of the process over time.
 - h. Events that do not require a Root Cause Analysis will have an incident review completed by Quality/Risk Services Department as soon as practicable of becoming aware of the event. The results will be forwarded to leadership for review.

Response to Reported Adverse/Sentinel Events

Reporting of events is an essential component of a Patient Safety/Risk Management program. Through its participation in the CHPSO; all related investigation of events will be securely conducted, collected and documented as Patient Safety Work Product (PSWP) to maintain confidentiality as defined in the Federal Regulation.

- A. Siena shall respond to all reported potential and actual adverse/sentinel events. (See Sentinel Event policy).
- B. Minimally, all adverse events will be analyzed utilizing a team of individuals including Risk Management/Patient Safety and Quality Departments, to conduct root cause analysis (RCA), incident review and/or a failure mode effects analysis (FMEA), implementation in action plan to reduce further risk to patients and establish measures of effectiveness.
 - a. The following events always elicit an intense analysis:
 - i. Confirmed transfusion reactions
 - ii. Significant adverse drug reactions
 - iii. Significant medication events and hazardous conditions

- iv. Minor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
 - v. Significant adverse events associated with anesthesia use.
 - vi. Hospital acquired infections
 - vii. All events meeting the definition of Sentinel Events in the State of Nevada.
 - b. A root cause analysis is performed when a sentinel or State reportable event occurs.
 - c. An incident review is performed when a near miss or other event with significant areas for improvement are identified.
- C. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
 - a. A “JUST CULTURE” approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
 - b. Involved staff should be involved in the RCA process.
 - c. The Department Manager will provide ongoing support to the staff member(s) as needed.
 - d. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

Education

- A. Staff Education
 - a. General orientation and other education and training programs as needed will emphasize specific job related aspects of patient safety and risk reduction strategies.
 - b. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
 - i. An overview of the Patient Safety Program
 - ii. Overview of TJC National Patient Safety Goals
 - iii. Staff’s role and responsibilities in the Patient Safety/Risk Management Program
 - iv. Event reporting criteria and process
 - v. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care
 - vi. Examples of specific job related aspects of patient safety.
 - c. Staff participating at a higher level of the Patient Safety/Risk Management Program will receive appropriate training necessary to understand and complete their assigned responsibilities.
- B. Physician Education
 - a. An overview of the Patient Safety/Risk Management Program will be provided to physicians at time of initial appointment and annually thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
 - b. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

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

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



Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Siena Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

Once the problems are identified, a Fishbone Diagram will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Whys technique also can be used to drill down the problem and find the root causes.

Model for Improvement

Please refer to the Dignity Health – St. Rose Dominican Performance Improvement Plan.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Siena is using IVOS_for tracking the sentinel events, healthcare infection data, and Midas for internal data collection.

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

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

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>

Approval of Patient Safety Plan

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

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

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

Patient Safety Program Reporting and Review

All patient safety work product (PSWP) submitted through the CHPSO will be collected in the Patient Safety Evaluation System (PSES) for collection, management and analysis of information pursuant to the Patient Safety and Quality Improvement Act of 2005 (42 U.S.C. 299 et seq.).

- A. Patient safety/Risk Management related data and information reports will be provided routinely to various committees as previously identified including but not limited to medical staff, Quality Council and QCAC.
- B. A summary report of data, other internal and external information, as well as all actions taken by various committees and/or specific patient safety related teams will be submitted to the QCAC and the MEC.

- C. Annually, the Patient Safety/Risk Management Plan will be evaluated for effectiveness and the program updated to reflect the results of risk assessments related to patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.
- a. The review will be approved by QCAC.
 - b. Will be submitted to the Community Board for final review and approval.

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Reviewed/Approved:

Patient Safety Committee, January 2019

Quality Care Advisory Committee of the Board, January 2019

Community Board, January 2019

TENAYA SURGICAL CENTER, LLC

PATIENT SAFETY PLAN

Plan: To understand and prepare the patient for outpatient surgery and/or procedure in order to improve outcomes.

- Patients are adequately prepared pre-operatively
- Patients and caregivers are well educated for pre- and post-operatively for self-management after surgery
 - To include Medication Reconciliation
- Providers are fully informed of their patient's physical status as it pertains to their surgery/procedure
- The surgery/procedure is appropriately marked and performed (correct-site), clinically accurate, and pertinent to the diagnosis
- Tenaya Surgical Center, LLC (TSC) will follow the Nevada State statutes as it pertains to controlled substance prescribing
 - Patient teaching will encompass instructions on the safe use and disposal of controlled substances

Review:

Safe Environment of Care

TSC's policies will follow the guidelines set forth by the Centers for Disease Control and Prevention (CDC) with excerpts taken from the Association of periOperative Registered Nurses (AORN).

The facility itself will maintain an atmosphere of safety with no hazards in the hallways, no wet floor surfaces or other examples that may prove hazardous to the patient and/or staff.

Risk factors include, but are not limited to:

1. Patient age greater than 85 years
2. Peripheral vascular disease
3. Operating room (OR) time greater than one hour
4. Malignancy
5. Positive HIV status
6. Heart disease
7. General anesthesia
8. Obstructive sleep apnea
9. Hyperactive reactive airway disease
10. BMI >30, especially over 35
11. Any chronic disease affecting internal organs

Risk Assessment:

The pre-operative assessment process starts when the surgeon or the interventionist schedules the case. In general, the goal of the pre-op assessment is to identify and manage any risks associated with surgery

and anesthesia as early in the process as possible. However, the assessment process continues up to the point of surgery.

Anesthesia Society of America (ASA) Physical Status Classification System Guidelines used by anesthesia providers to evaluate a patient's risk for anesthesia and surgery, excerpted as follows:

ASA 1: A normal healthy patient

ASA 2: A patient with mild systemic disease

ASA 3: A patient with severe systemic disease

ASA 4: A patient with severe systemic disease that is a constant threat to life

ASA 5: A moribund patient who is not expected to survive without the operation

ASA 6: A patient that has been declared brain-dead, whose organs will be removed for donor purposes

Patients classified as ASA 5 or 6 will not have procedures done at TSC. It is left up to the discretion of the operating surgeon or interventionist and the anesthesiologist whether or not to perform a procedure on a patient with an ASA classification of 4.

Pre-operative Screening:

The initial screening process is the first step in identifying any concerns or disease processes that could potentially cause intra- or post-operative problems. AORN has issued a guidance statement for a nursing pre-operative evaluation in the ambulatory surgery setting. The initial step is careful pre-operative screening, which is initiated by the pre-operative telephone interview. It is the policy that all patients, except for cosmetic surgery patients, are called the day prior to their procedure by a registered nurse (RN). The screening includes the following:

- A baseline physical assessment
- Allergies and sensitivities
- Cultural, emotional, and socioeconomic assessment
- Pain assessment
- Medication history; to include prescription medications, over-the-counter medications, herbal medications and supplements, opioid and other controlled substances, cannabinoids, and illicit substances. Included is the frequency, dosage and time last dose taken
- Anesthetic history, including adverse reactions to any form of anesthesia
- Results of radiological examinations and other pre-operative testing
- Discharge planning
- Referrals
- Identification of physical alterations that require additional equipment or supplies

- Pre-operative teaching, including which medications are to be taken or withheld before surgery and NPO requirements
- Development of a care plan
- Documentation and communication of all information

Pre-operative Nursing Assessment:

After the pre-operative screening is completed, the pre-operative nursing assessment is an opportunity to verify information and obtain missed or forgotten information that may affect patient outcomes. The AORN guidance statement recommends that an RN conduct a pre-operative nursing assessment on the day of surgery. TSC follows these recommendations. Information obtained during the pre-admission screening is verified. During the assessment, the following data is obtained:

- Verification of the patient's identity using two identifiers
- Review of the pre-admission screening/assessment
- Baseline physical assessment
- Assessment of NPO status
- Hypo/hyperthermia assessment and management
- Pain scale assessment
- Identification of the presence of an advanced directive
- Identification of the planned procedure by the patient, significant other, or guardian and verified with the consent and surgical schedule
- Verification of the site, side, or level, as applicable
- Informed consent signed and witnessed. Patient verbalizes understanding of the procedure listed. If no understanding, the surgeon or interventionist notified so he/she can answer any questions the patient may have.
- Signs of abuse or neglect in vulnerable populations, to include pediatrics, geriatrics, and others at risk
- Assessment for prosthetic devices and implantable electronic devices
- Evaluation of the availability of safe transportation home and aftercare
- Obtaining contact information of the patient's significant other
- Assessment of the patient's understanding of pre-operative teaching and discharge planning
- Assessment of DVT risk and prophylaxis
- Fall assessment and prevention
- Assessment of communicable disease risk and procedure to follow if positive

Pre-operative Anesthesia Assessment:

The pre-operative anesthesia assessment is the part of the overall assessment process that identifies issues related to peri-operative anesthesia management of the patient. The anesthesiologist shall see the patient prior to the procedure to inform the patient of the plan of anesthesia and to answer any questions the patient may have in regards to anesthesia.

Post-anesthesia Care:

Patients should have a complete systems assessment during the first few minutes of PACU care. This assessment should include, but is not limited to:

- Vital signs
- Respiratory adequacy
- Post-operative cardiac status
- Peripheral circulation
- Post-operative neurological status
- Level of consciousness, including alertness, lucidity and orientation
- IV patency
- Allergies and sensitivities
- Pain management
- Motor abilities
- Return of sensory and motor control in areas affected by local or regional anesthetics
- Skin integrity
- Temperature regulation
- Positioning
- Surgical wound site
- Nausea and vomiting
- Fluid and electrolyte balance

The post-anesthesia nurse should provide ongoing assessments and re-evaluations concurrently with nursing interventions.

Post-operative Patient Outcomes

Nursing interventions are initiated to achieve a desired conclusion and/or to reduce the probability of patient outcomes that may be associated with a patient's post-operative experience.

Discharge Criteria

The patient's post-procedure status should be assessed before he or she is discharged from the PACU. The Aldrete score at discharge must be at least an eight. If not, then documentation from the RN must exist to justify discharge, along with an assessment and discharge order from a physician. If possible, the patient will be discharged in the company of a responsible adult. Occasionally, a patient may not have someone to pick

them up and will request to go home via public transportation. If undergoing Monitored Anesthesia Care, (MAC), then it is up to the interventionist and anesthesiologist to allow this to happen. If an order is obtained, the patient may spend a longer period of time in the PACU, if necessary, to allow for maximum alertness. In this instance, the Aldrete score should be nine or over. Any patient undergoing general anesthesia is told to have a responsible adult with them for the first twenty-four hours after anesthesia. If this is not possible, surgery may be cancelled and rescheduled for a more opportune time. If the patient wishes to leave against medical advice, then the policy for this shall be followed.

Discharge criteria includes an evaluation of the patient for nausea, pain, surgical site condition and bleeding.

Patient Transfer

Whenever a patient is transferred from one level of care to another level of care, the peri-operative RN is to communicate all pertinent information to the next caregiver. This is to include, but is not limited to:

- Vital signs and airway patency
- Level of consciousness
- Allergies
- Condition of operative site/dressing
- Location and patency of tubes and/or drains if applicable
- Medications given and response
- Intake and output
- Tests ordered with results, if available
- Pain level
- Nausea and vomiting psychosocial status, and
- Discharge orders

The policies and procedures on emergency transfer will be followed and the patient to be transferred to a hospital who has a transfer agreement with TSC, i.e. Mountain View Hospital, Summerlin Hospital or Spring Valley Hospital.

Discharge Instructions and Discharge

The written post-operative care instructions shall be provided to each patient and shall be reviewed with them and their caregiver prior to discharge. Either the patient or the caregiver shall verbalize understanding of these instructions prior to release. The discharge information includes what to expect after the surgery or procedure, what not to expect after surgery or the procedure and information on how to contact their doctor, both during and after office hours. If the patient has been provided with a prescription for medication, the medication should be reviewed with the patient, including how to use the medication, the side effects, signs and symptoms to report and when to contact the health care provider for additional assistance.

The discharge instructions will be tailored to the patient and the type of procedure.

When discharging the patient, the nurse shall take the patient to his/her car by wheelchair and assure he/she is properly positioned in the vehicle. If the patient has had MAC anesthesia, then he/she may walk out with the assistance of medical care personnel to ensure he/she ambulates safely to the vehicle.

3066 Red Rock Surgery Center

Hand, Eye, Foot, General, ENT, Dental, Detox, Pain

7135 W Sahara Ave #101, Las Vegas, NV 89117

(702) 227-5848

SUBJECT: PATIENT SAFETY PROGRAM

POLICY:

The patient safety program integrates risk management, performance improvement, and a review of processes, functions, and services to improve safety by reducing the risk of system or process failures.

By establishing a system and providing training to encourage the reporting of unanticipated events, the organization can review sentinel events as well as a process variation which does not affect the outcome or result in an adverse event, but for which a recurrence carries significant chance of a serious adverse outcome or result in an adverse event, often referred to as a “near miss”.

Data analysis of unanticipated events will be used to identify and implement changes that will improve the quality of care, treatment, and services and reduce the risk of sentinel events occurring.

A patient safety officer will be appointed and patient safety committee will promote the health and safety of patients, review and evaluate the quality of patient safety measures used in the Center to assist with implementation of the patient safety plan. This patient safety committee can be the same members as the quality improvement/performance improvement committee and employee safety committee, reviewing all areas of performance, safe work environment, and safe patient care processes.

SUBJECT: MANAGEMENT RESPONSIBILITIES

1. Management will appoint a patient safety officer to be responsible for risk management and patient safety activities.
2. State specific reporting requirements must be followed to comply with regulations for the reporting of certain adverse patient outcomes. The patient safety officer will be familiar with the State regulations regarding what must be reported regarding adverse patient outcomes or facility damage such as fire, flooding, or wind damage.
3. If the Surgery Center is accredited, the accrediting body may also require reporting at the time of the adverse outcome. During an accreditation survey, a surveyor will likely review whether the Center management conducted a systematic review of the unanticipated event, including an analysis of how it occurred with an action plan to prevent similar unanticipated events in the future.
4. To promote patient safety, Center management will review unanticipated events to determine if a process change is required to reduce the potential of further unanticipated events. Unanticipated events that involve patient injuries, "near misses", and unexpected outcomes will be reviewed by the patient safety officer.
5. There will be an ongoing evaluation of procedures, protocols, and systems to accurately identify patients, planned procedures, and the correct site of the planned procedure so as to minimize the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition.
6. When risk management and patient safety services are provided by an outside consultant, the professional services agreement will be approved by the Governing Board which approves all outside service agreements. This approval must be documented in minutes of the Governing Board meeting or by the signature of the Governing Board Chair on the agreement or appointment letter.
7. Employees will receive education on the Risk Management/Patient Safety program and participate in activities.
 - a. The policies and procedures will be reviewed.
 - b. The purpose and completion of the Unanticipated Event Report form will be discussed.
 - c. Each employee will complete the risk management quiz and the answers will be reviewed and discussed so that everyone understands the duties and responsibilities. This quiz will be filed in the employees' educational records to document their participation in patient safety and risk management education.

- d. All new employees will receive training within the first 30 days of work.
 - e. Patient safety and risk management may be discussed at staff and committee meetings throughout the year.
 - f. Annually the employees will receive risk management/patient safety education. The key points covered in the educational program and attendance will be recorded in the employees' educational records to document their annual risk management/patient safety education.
8. The patient safety officer must contact management immediately if any of the following occur:
- a. Adverse Incidents
 - i. any unexpected occurrence involving a serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition;
 - ii. any process variation for which a recurrence carries a significant chance of a serious adverse outcome;
 - iii. events such as breaches in medical care; administrative procedures or other breaches resulting in a negative impact on a patient, even where death or loss of limb or function does not occur
 - b. Unanticipated Events, including
 - i. notification by a patient or attorney of the intent to sue;
 - ii. unanticipated and unplanned transfer to a higher level of care as a result of action or inaction that occurred at the surgery center.
 - c. Any of the following sentinel events:
 - i. death of a patient;
 - ii. brain or spinal damage to a patient;
 - iii. performance of a procedure on the wrong patient;
 - iv. performance of a wrong-site procedure;
 - v. performance of a wrong procedure;
 - vi. procedure unrelated to the patient's diagnosis or medical needs;
 - vii. procedure to remove foreign objects remaining from a previous or just completed procedure;
 - viii. repair of injuries or damage from a planned procedure where the damage is not a recognized specific risk as disclosed to the patient and documented through the informed consent process.

9. The patient safety officer, with assistance as needed from staff and the Medical Director, will review reports to identify the basic or causal factors that underlie the variation in performance. If the report involves an adverse event or a “near miss” of an adverse event, an analysis will be completed within 10 days of the time the patient safety officer is notified of the event. An action plan will be established and implemented to reduce the risk of similar incidents occurring. The action plan must address responsibility for implementation, oversight, testing when appropriate, time lines, and measurement of the effectiveness of the actions. The 10 day period for completion of the analysis may be extended if reports, such as laboratory results, autopsy findings, consultative findings or hospital discharge summaries are pending. However, as much information as possible should be gathered. If the analysis cannot be completed within 45 days, the patient safety officer must submit justification to the Medical Director and Administrative Director.
10. The patient safety risk management policies and procedures will be available for all employees for reference.
11. Blank Unanticipated Event Report forms will be available and the employees will be advised where they can locate the supply of forms.
12. When an unanticipated event occurs, an Unanticipated Event Report form will be completed by the employee who will present the form to the patient safety officer.
13. The patient safety officer will learn the circumstances and make all efforts to determine what happened, who was involved, what injury or potential problem occurred, the cause of the injury or potential problem, and the status of any injured persons.
14. A patient may request a different health care provider. If this should occur, the supervisor and the Medical Director will confer and review with the patient the opportunities to select another provider.
15. Periodically, the patient safety officer or designee will review the medical records for appropriateness and completion of the medical records. This review will include forms used, how they are completed, and signatures, as well as the clinical record policies. Particular attention will be paid to the consent process documentation and the documentation of the “time out” to verify correct patient, correct site, correct surgery.

Title:	Patient Safety Program	Department:	Quality Management
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Tahoe Pacific and Complex Care Hospital of Tenaya Patient Safety Program

Purpose

Tahoe Pacific Hospital and Complex Care Hospital of Tenaya have developed a Patient Safety Program in conjunction with the Performance Improvement Plan and Program, the Risk Management Plan and Program, and the Hospital Scope of Services, in order to provide guidelines for implementation of an integrated patient safety program throughout the hospital and to comply with the requirements of the state of Nevada. It is the intent of the leadership of the hospitals to foster a safe and safety-conscious environment that promotes well being, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvement.

Scope

Overall Patient Safety responsibilities include the following:

1. Improve the accuracy of patient identification. Through the use of 2 patient identifiers whenever performing procedures, administering medications or blood, taking blood samples or other specimens, or providing any other treatments or procedures.
2. Improve the effectiveness of communication among caregivers as contained in Handoff Communication Guidelines, Located under Best Practices in LifeCare Policies and Procedures
3. Improve the safety of using high-alert medications as contained in the LifeCare policy, Medication Safety: High Alert Medications
4. Ensure the identification, reporting, prevention and control of infections, including the role of proper hand hygiene as contained in the LifeCare policies, The Infection Control Plan and its addendums; Hand Hygiene, and other policies covering Blood and Body Fluid Exposure, Environmental Disinfection, Single Use of Drugs and Devices and Use of Isolation Precautions as contained in the Quality Management policy section.
5. Reduce patient falls and injuries from falls as contained in the LifeCare policy, Fall Prevention, through recommendations from the Falls Committee Performance Improvement Team and information about falls gathered from the Post Fall Assessment Form.
6. Improve the effectiveness of clinical alarms systems as contained in the LifeCare policy, Safety – Alarms- Clinical Equipment.
7. Identifying, preventing and correcting errors in the labeling, storing, prescription or administration of medications as contained in the LifeCare policies, Medication Storage, Dispensing – Labels, Dispensing Medications – General, and other policies contained in the Pharmacy section.
8. Ensuring the safe administration of prescription drugs, controlled substances, pharmaceutical services and other medications as contained in the LifeCare policy, Administration of Drugs, and other policies contained in the Pharmacy section.
9. The identification, investigation and reporting of Sentinel Events as contained in the LifeCare policy, Sentinel Events, and as prescribed by NRS 439.800 and following

Title:	Patient Safety Program	Department:	Quality Management
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guidelines established by the Nevada State Health Department's Sentinel Event Registry. The Patient Safety Officer will also be responsible for the maintenance of Sentinel Event records.

10. Oversight of the maintenance of a sanitary environment by the facility through conduction of Environmental Rounds, Infection Control Rounds and day to day observations by supervisory and charge staff, as contained in the LifeCare policies, Safety Management Plan,; the Infection Control Plan, and other policies under Quality Management and Engineering.
11. Adoption and implementation of patient safety checklists to improve the health outcomes of patients in the medical facility and ensure the knowledge to provide care safely is applied consistently and correctly. These checklists may include best practices and competencies for treatments ordered by an independent licensed practitioner. Other examples may include the proper sequence for environmental cleaning and proper use of personal protective equipment. Also included are discharge checklists explaining discharge medications, aftercare instruction and other instruction needed at discharge. Current examples in use include:
 - a. Insertion of PICC lines.
 - b. Maintenance of foley catheters
 - c. Discharge checklist
 - d. Respiratory Treatment competencies

The primary focus of the Patient Safety Program is the patient; however the program also addresses the safety of visitors and staff from all clinical and organizational functions. The scope of the Patient Safety Program includes but is not limited to the occurrence of the following:

1. Adverse Drug Reactions
2. Falls
3. Restraints
4. Medication Errors
5. Hazardous Condition(s)
6. Near Misses
7. Sentinel Events

The role of the Patient Safety Program also crosses over into the safety of the environment of the hospital including oversight of the 7 Environment of Care Plans:

1. Safety Management Plan
2. Security Management Plan
3. Life Safety Management Plan
4. Medical Equipment Plan
5. Emergency Preparedness Plan
6. Hazardous Materials and Waste Management Plan,
7. Utilities – Utilities Management Plan

Title:	Patient Safety Program	Department:	Quality Management
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Annual Reviews of each of the 7 plans are performed annually and reported to the Environment of Care Committee, the Medical Executive Committee and the Governing Board

Methodology

The Patient Safety Program includes both proactive and responsive components.

Proactive: The proactive patient safety component emphasizes a proactive error reduction and avoidance program. The following will be reviewed to proactively identify patient safety issues:

1. Medical equipment and medication risk assessment activities
2. Sentinel event alert risk reduction activities
3. Performance improvement indicators and monitoring activities
4. Patient Satisfaction reports
5. Medical Record review reports
6. Staff orientation, evaluation, training, and education activities
7. Failure Mode and Effect analysis (FMEA) activities
8. Medical Staff Credentialing issues
9. Occurrence Report trending

Failure Mode Event Analysis (FMEA) will be conducted annually. The process to be studied each year will be determined in collaboration with medical staff, hospital leadership, and staff. Information from patient safety organizations such as the Institute for Medicine, Institute for Safe Medication Practices, and The Joint Commission will be disseminated to the appropriate departments and committees for action and implementation of recommendations.

Responsive: The hospital will utilize information gathered from risk assessments, sentinel event alerts, performance improvement measures, medical record review, and other data in order to track, trend, and respond to patient safety issues. Patient safety related issues will be ranked based on severity. The following will be reviewed for reactive patient safety issues.

1. Root Cause Analysis
2. Intensive Assessment and Analysis
3. Occurrence Report Findings
4. Patient Complaint Response
5. Performance Improvement Measures
6. Patient Satisfaction Survey Reports

Patient Safety Committee and Reporting

Patient Safety is the responsibility of all employees and Medical Staff members. The Patient Safety Program will be multi-faceted and that responsibility will be shared among several individuals, groups, and teams. Each performance improvement team is

Title:	Patient Safety Program	Department:	Quality Management
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transdisciplinary in nature with representatives from the hospital and medical staff. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement teams are sent to the Quality Council and reported to the Medical Executive Committee and the Governing Board.

In compliance with State of Nevada Regulations, the Patient Safety Committee will be comprised of:

- (1) The patient safety officer of the medical facility.
- (2) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.
- (3) One member of the executive or governing body of the medical facility.

The Patient Safety Committee is also transdisciplinary with representation from the following areas: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management, and the Hospital's Infection Control Preventionist.

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:
 - a. Risk and Safety Management
 - b. External Data Reports
 - c. Sentinel Event Alerts from The Joint Commission
 - d. Healthcare Reports
 - e. Regulatory Reports
 - f. Patient/Family Members
2. Continually improve processes of care delivery based on data analysis.
3. Develop policies and procedures that result from process improvement activities.
4. Develop and approve Patient Safety Education for the medical and hospital staff.
5. Conduct an annual risk assessment of patient safety issues/strategies from internal and external reports.

The Hospitals believe in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent

Title:	Patient Safety Program	Department:	Quality Management
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mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator.

The activities of the Patient Safety Program and an annual review of the Patient Safety Plan, it's appropriate policies, forms, checklists and best practices will be reported to the Patient Safety Committee, the Medical Executive Committee, and the Governing Board as outlined in the Performance Improvement Plan and the LifeCare Reporting Calendar. Communication within the hospital and medical staff is the key to a successful patient safety program and will be encouraged.

Education and training is an important and effective tool in assuring that the Patient Safety Program is clearly understood, particularly error identification and reporting and the basic approaches to Patient Safety. Education and training on patient safety is included in new employee general and department orientation and reviewed annually. Additionally, education will be provided to patients and their families about their role in helping to facilitate the safe delivery of care.

Policy#: 180	Title: Patient Safety Plan	Category: Plans
Policy Status: Published	Effective Date: 02/05/2018	Last Reviewed Date: 03/27/2018

PROCEDURE

PURPOSE:

The purpose of the Patient Safety Program is to improve patient safety and reduce risk to patients, staff and visitors. Recognizing the effective medical/health care error reduction requires an integrated and coordinated approach; we have developed an organization-wide safety program. The program supports the creation of an environment in which patients, their families, and organization staff leaders can identify and manage actual and potential risks to patient safety.

OBJECTIVE:

It is our objective to foster an environment to improve patient safety, establish mechanism to support effective responses to actual occurrences and to be proactive in the reduction of medical/health care errors. Patient safety will be a priority in new design and all relevant organization processes, functions and services.

SCOPE:

The scope of the patient safety program will include compliance with standards identified by external regulatory agencies and accrediting bodies. Program activities will address occurrences ranging from "near misses" to sentinel events with serious adverse outcomes.

DEFINITIONS:

Actual Event-an event occurred that reached the patient or individual (e.g., visitor fall, student injury, etc.).

Near Miss-an event occurred but it did not reach the patient because of chance alone or because of active recovery efforts by caregivers.

Unsafe Condition- circumstances that could cause adverse events (e.g., look-alike medications, confusing equipment, failure to use proper signage when floor is wet).

Sentinel Event- is defined as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Severe temporary harm which is defined as critical, potentially life-threatening harm lasting for a limited time with no permanent residual effect, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition. (Hip fractures are always included)
- Permanent harm
- Death

For additional events also considered "sentinel" reference the HealthSouth Sentinel Event policy

PROCEDURES:

A. The responsibility for management of the organization-wide patient safety program is assigned to the Director of Quality/Risk Management.

1. The Safety Committee and Quality Council will provide interdisciplinary input related to patient, visitor and staff safety.

2. Reports of safety related activities and issues would be presented to Department Managers, Senior Staff, Medical Staff via the Medical Executive Committee, and the Governing Board. This communication is confidential and for quality assurance purposes only.

B. Staff will report information relating the medical/health care events as outlined in Risk Management Electronic Event Reporting Policy.

1. Staff will be oriented to the Risk Management Policies on hire and through ongoing in-service and other education and training programs.

2. Staff will be oriented to their roles in preventing adverse occurrences as related to their specific job responsibilities and as a part of the organization-wide efforts to improve patient safety.

3. Staff will be oriented to the importance of reporting "near misses," as well as adverse occurrences.

4. Team training to foster an interdisciplinary, collaborative approach to patient care delivery and to reinforce the need and way(s) to report medical/health care errors will be provided as appropriate.

5. The Director of Quality/Risk Management, Department Managers, and Senior Staff are responsible for interacting with staff in a manner that ensures staff do not fear disclosure, embarrassment, blame or punishment for reporting potential or actual events related to patient safety.

6. The Director of Quality/Risk Management, Department Manager and/or Senior Staff member may request the assistance of internal behavioral management staff or external resources if a staff member(s) needs support in coping with a sentinel event.

C. Hospital leadership will identify barriers to effective communication among caregivers relative to patient care, redesign the process to eliminate barriers and monitor for effectiveness. Specific attention will be directed to:

1. Process for ensuring accurate, timely, and complete verbal and written communication among care givers and all others involved in utilization of data, and

2. Test results relative to the management of the patient's condition.

D. All patients are entitled to information about all aspects of their health care, including information about clinically relevant unanticipated outcomes of care.

Patients and, when appropriate, their families are informed about the outcomes of care including unanticipated outcomes (i.e. sentinel events, State reportable events). Responsibility for disclosing unanticipated outcomes typically rests with the physician or designee who has overall responsibility for the patient's care. However, in some situations, other healthcare professionals may be deemed more appropriate to be responsible for disclosing the outcome. A hospital representative, preferably the Quality/Risk Director, Chief Nursing Officer or the Chief Executive Officer should be present for the initial conversation and any follow-up discussions that may occur with the patient and/or patient's representative.

E. The Director of Quality/Risk Management or designee will respond immediately to notification of significant medical/health events to a patient/visitor or staff member.

1. The Nursing Supervisor or Department Manager will contact the Risk Manager and/or Administrator/Administrator-On-Call to report events.

2. Action(s) will be taken to protect the patient/visitor/staff members as indicated per hospital plans and policies.

3. Factual information will be obtained and preserved for subsequent analysis. Such information is confidential for quality assurance purposes.

F. The facility will review historical risk management, Environment of Care (EOC), Program Improvement (PI) and Human Resources (HR) data for high volume, high risk problem trends in medical and care processes, as well as unanticipated adverse occurrences affecting patients. These will be ranked as:

- A. Unsafe condition (Non-event)

- B1. Near Miss - No Harm/Didn't Reach Patient/Caught by Chance
- B2. Near Miss - No Harm/Didn't Reach Patient b/c of Active Recovery by Caregiver
- C. No Harm – Reached Patient No Monitoring Required
- D. No Harm – Reached Patient Monitoring Required
- E. Harm – Temporary, Intervention Needed
- F. Harm – Temporary, Hospitalization Needed
- G. Harm - Permanent
- H. Harm – Permanent, Intervention Required to Sustain Life
- I. Death

G. The facility will also perform intense analysis consistent with the Root Cause Analysis/Sentinel Event Policies, and reports as required by state, regulatory, and accreditation bodies. The Risk Management designee is responsible for ensuring compliance with reporting.

H. Emerging needs requiring reprioritizing performance improvement activities may be identified through data collection and assessment, unanticipated adverse occurrences affecting patients, changing regulatory requirements, significant patient and staff needs, changes in the environment of care, or changes in the community. Priority consideration in establishing performance improvement teams is given to:

1. Processes that affect a large percentage of patients.
2. Processes that place patients at risk, if not performed well, if performed when not indicated, or if not performed when indicated.

Processes that have been or are likely to be problem prone.

I. When designing/redesigning processes, Department Managers and staff will:

1. Incorporate information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesigned process, function or service.
2. Conduct literature searches to obtain evidence based medical and/or care practices to be included in process redesign.
3. Include analysis and or pilot testing to determine whether the proposed design/redesign is an improvement.

J. Hospital leadership will consider the importance of patient safety in:

1. Development of hospital-wide patient care programs, policies and procedures that describe how patients' care needs are assessed and met.
2. Development and implementation of the hospital's plan for the provision of patient care.
3. Decision-making structures and processes.
4. Implementation of an effective and continuous program to measure assesses and improves performance.
5. Development of an interdisciplinary culture that emphasizes cooperation and communication. The leadership role of coaching will be used to promote communication among services, individual staff members and less formal structures such as quality action teams, performance-improvement teams or members of standing committees.
6. Development of a process to involve the patient, as appropriate to his/her condition, as a partner in helping to facilitate the safe delivery of care.
 - a. Patients/family members are oriented on admission of the importance of reporting perceived risks and concerns about the patient's care per Patient and Customer Complaint and Grievance Policy.
 - b. Department Managers and Senior Staff will review Press Ganey Patient Satisfaction Survey questions related to patient safety and develop a corrective action plan to patient/family complaints or suggestions for improving safety as appropriate.
7. The Governing Board will appoint the Director of Quality and Risk Management (DQR) as the Patient Safety Officer. The Patient Safety Officer/Director's role includes:

- Participating in hazard surveillance, event reporting, reviewing, and the development of patient safety policies and procedures.
- Analyzing and seeking resolution of patient safety issues and works with the appropriate staff to implement recommendations and to monitor patient safety improvement activities.
- Report on findings, recommendations, actions taken, and results of measurements through the hospital quality structure.

K. At least one (1) high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance, a minimum of 1 proactive risk assessment every 18 months. The process selected will be based, in part, on the information identifying the most frequently occurring sentinel events and patient safety risk factors.

1. Assess the intended and actual implementation of this process to identify steps in the process where there is, or may be, undesirable variation (i.e. called potential "failure modes").
2. For each identified "failure mode, "identify the possible "effect(s)" and how serious the possible effect on the patient could be (i.e. "criticality "of the effect).
3. For the most critical effects, conduct a root cause analysis to determine the variation (failure mode) leading to that effect occur.
4. Redesign the process and/or underlying systems to minimize the risk of that failure mode to protect patients from the effect of that failure mode.
5. Test and implement the redesigned process.
6. Identify and implement measures of the effectiveness of the redesigned process.
7. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

L. Hospital leadership will measure and assess the effectiveness of their contributions to improving patient safety. To accomplish these goals, leaders will.

1. Set measurable objectives for improving patient safety.
2. Actively request staff to periodically discuss their opinions, needs, perceptions of risks to patients and suggestions for improving patient safety. The actions taken as a result of this staff input will be reported to the MEC/GB bi- annually.
3. Review data on staff willingness to report medical/health events.
4. Review data from Patient Satisfaction Survey related to patient safety.
5. Use pre-established, objective process criteria to assess their effectiveness in improving patient safety.
6. Draw conclusions based on their findings and develop and implement improvement in their activities.
7. Evaluate their performance in supporting sustained improvement.

M. The DQR will report at a minimum quarterly to the Governing Board occurrences of medical/health events and actions to improve patient safety.

Close

Encompass Health Rehabilitation Hospital of Henderson

Policy#: 160	Title: Performance Improvement Plan	Category: Plans
Policy Status: Published	Effective Date: 02/05/2018	Last Reviewed Date: 02/05/2018

PROCEDURE

I. Mission, Values, Customers

Our Mission: To be the healthcare company of choice for patients, employees, physicians and shareholders by providing high quality care in the communities we serve.

Our Values: The cornerstone of our operations is the delivery of quality healthcare in the most appropriate, safe, patient-centered environment. We place primary value on:

QUALITY

We provide our patients with the finest clinicians, technology, facilities and programs available. We do this in a safe environment,

Responding to the needs of our diverse patient population, always working to achieve superior outcomes for each patient in a professional, caring and cooperative manner.

INTEGRITY

We consider trust and integrity to be essential in all our relationships. We are committed to operating our business honestly, with financial integrity, and in adherence with all

Federal, state and local regulatory obligations affecting the operation of our business.

COST-EFFECTIVENESS

We are committed to providing high quality healthcare in an innovative, yet cost-effective manner, managing our resources wisely, and responding proactively to the changes in our industry. We seek to develop relationships with a diverse array of business partners that share similar values and conduct business in an ethical manner.

RESPECT

We respect and embrace the diversity all of our employees bring to the hospital. We provide opportunities for our employees' growth and development and encourage their participation in an open and inclusive culture. In addition, we respect our patients, physicians, shareholders, business partners and vendors, recognizing the valuable, unique roles each of them plays in our business and striving to communicate with them openly and honestly.

Our Customers are defined as those individuals, both external and internal to the organization, who have a vested interest in the outcomes of the hospital, whether those outcomes are financial, regulatory, or clinical in nature. The organization considers the employee as a customer, as no outcomes are possible without their input.

CUSTOMERS

EXPECTATIONS (Strategic Focus Areas)

PATIENTS

Superior care, work toward the best outcomes possible, and dealings will be courteous, professional, and cooperative while maintaining dignity.

THEIR FAMILIES	Assurance, information, participation in rehabilitation processes
OUR STAFF	Individuality, opportunities for growth and development, participation in decision making, individual and corporate citizenship
PHYSICIANS	Quality care, easy access, communication, positive outcomes
COMMUNITY	Commitment to community values, positive influence in general and specifically in returning citizens to productive lives
STOCKHOLDERS & PARTNERS	Provision of financial and operational management, which provides for a structure of acceptable financial performance and return on the investment by the stockholders.

The Strategic Focus Areas are those issues, processes, or systems that are imperative for the successful operation of the hospital. These areas are not the responsibility of a single individual, but rather encompass the entire staff of employees, volunteers, and members of the Medical Staff. Listed below are the strategic focus areas. Each has simple measures to identify those areas for improvement that may prevent the successful operation of the hospital. Every measure has assigned responsibility for the measurement and reporting of the data and information surrounding the measurement. Although there is responsibility assigned, a team is required in most instances to improve the operations of the organization in order to meet the hospital goal. The Quality Council will review measurements in order to assist in hospital prioritization. Further reporting of the information is to occur to the Governing Body and/or Medical Executive Committee as appropriate.

STRATEGIC FOCUS AREA	INDICATORS OF SUCCESS
FINANCIAL MANAGEMENT	Variable Expense Revenue Cash Earnings
VOLUME GROWTH	Inpatient Volume Outpatient Volume
QUALITY OF CARE/OUTCOMES	Discharge Disposition Patient Satisfaction Resource Management
COMPLIANCE	Prospective Payment System Compliance Regulatory/Accrediting Body Surveys Internal/Self Audits
HUMAN RESOURCE MANAGEMENT	Human Resource Allocation Human Resource Productivity

In addition, additional measures that relate to the strategic focus areas that are equally important and required by law, regulation, or accrediting body will be collected and analyzed periodically and include, but are not limited to:

- Blood Use/Adverse Reactions
- Pharmacy and Therapeutic Medication functions
- Infection Control
- High Risk Process Assessment and Measurement
- Contracted Patient Care Services
- Risk Management/Patient Safety
- Medical Record Review/Clinical Pertinence
- Environment of Care
- Management of Patient Pain

The hospital will measure additional indicators as indicated by the performance of the hospital, but will be limited in an effort to have an effective and efficient PI mechanism.

Performance Improvement Dashboard/ Department Specific Data:

The PI Dashboard Grid (Quality Metrics Report) will be maintained at least quarterly, consisting of data from each department.

Hospital-Wide Indicators

Hospital-wide indicators will be monitored and reported a minimum of quarterly. Items include but not limited to:

- Patient Satisfaction
- Patient Outcomes
- Infection Control
- Risk Management
- Environment of Care
- Medical Record Review
- Medical Record Delinquencies

II. Purpose of Performance Improvement

The performance improvement activities of the hospital are a coordinated comprehensive and ongoing effort to assess the effectiveness of all care and services provided based on the mission, and values of the organization. The organization has a planned, systematic, organization-wide, and department specific approach to planning, designing, assessing, and improving its performance. The goal and purpose shall be to strive, with the resources available, for optimal outcomes with continuous, incremental improvements which are consistently representative of a high standard of practice with the medical community and community at large.

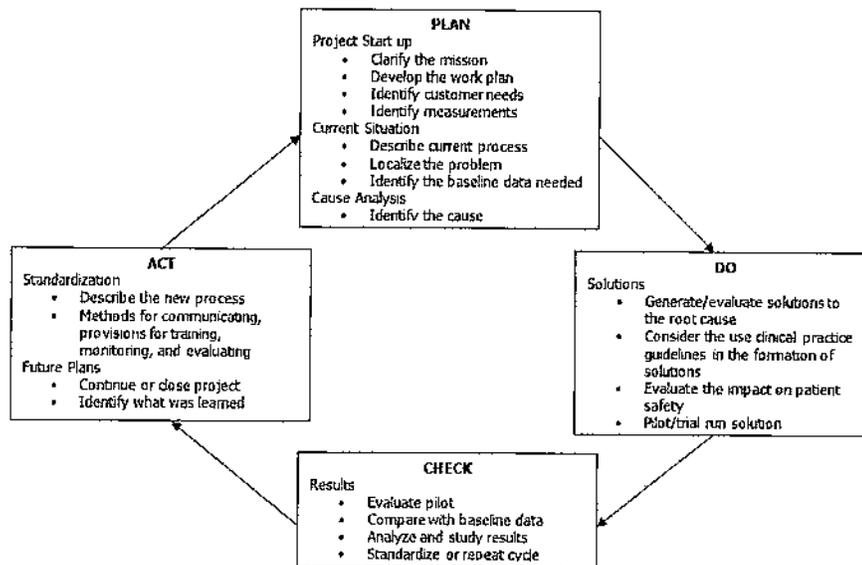
The plan is to minimize risks to patients, visitors, employees, and staff while improving the safety for patients. The attainment of the goals developed shall be in consideration of the internal and external customer needs with improvement processes focusing on improved patient outcomes, patient safety, and cost effectiveness. The goals are not limited to those departments and services that directly provide care to persons served, but all departments and individuals that are involved with the products provided by the organization.

III. Process Improvement Method

The organization shall utilize a systematic method to improve the organizational performance. Various methodologies have been assessed throughout the history of the organization. The most effective and simplest method is the use of the PDCA model.

- P - Plan**
- D - Do**
- C - Check**
- A - Act**

The above method is at the core of performance improvement activities throughout the organization and is incorporated in the logic of improving services at every level. Performance improvement techniques such as brainstorming, multi-voting, flow-charting, etc. will be utilized in improvement activities as appropriate to the team. Graphic representation of data and methods utilized during improvement processes is encouraged during presentations of activities and outcomes.

The Plan/Do/Check/Act Cycle

Additional proactive assessment of at least one high-risk process will occur every 18 months in order to reduce medical/health care errors. The selection of the process will occur based on information published from a variety of sources including, but not limited to, The Joint Commission (TJC). The study of the process will utilize the proactive risk assessment process outlined by TJC. Proactive risk assessment is similar to the PDCA process, but without specific data to support the process or an event to direct attention to a process that is undesirable. The proactive assessment is indeed a PI project and should not be separate from the performance improvement activities of the hospital.

Proactive Risk Assessment

1. Assess the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation (potential "failure modes").
2. For each identified failure mode, identify the possible effects on the patient ("effect"), and how serious the possible effect on the patient ("criticality" of the effect)
3. For the most critical effects, conduct a root cause analysis to determine why the variation (failure mode) leading to that effect occurs.
4. Change the process or system to minimize the risk of that failure mode or to protect patients from the effects of the failure mode identified. Utilization of clinical practice guidelines, when available and appropriate, for the process development in order to reduce variation.
5. Test and implement the redesigned process.
6. Identify and implements measures of the effectiveness of the redesigned process.
7. Implement a strategy for maintaining the effectiveness of the redesigned process.

IV. Roles and Responsibilities

The responsibility for the success of performance improvement is in the hands of every employee in the organization with specific roles and responsibilities determined to expedite organization wide efforts. The authority for implementing the performance improvement plan is afforded to the CEO by the Governing Body.

KEY ROLES

Governing Body

RESPONSIBILITIES

The Governing Body is the ultimate authority and is committed to the provision of quality and safe patient care and services. Reporting of organizational performance and improvement is reported at least quarterly with a summary of significant improvements and significant issues. Recommendations and guidance based upon the expertise,

knowledge, and HS Corporate planning will be provided for implementation by the organization. The responsibility to optimize the organizational performance through appropriate utilization of resources is directed by the Governing Body. The Governing Body, through its voting membership, shall facilitate Performance Improvement as follows:

1. Provide direction in setting priorities;
2. Oversee the planning, design, implementation, and ongoing monitoring;
3. Establish an organizational culture, which supports commitment;
4. Provide adequate resources; and,
5. Receive, review and accept reports regarding the effectiveness to help guide direction.

Quality Council

The Quality Council is responsible for overseeing the Plan by:

1. Monitoring and assessing data;
2. Acting on recommendations from staff, departments and patients and their families;
3. Identifying and prioritizing performance improvement projects;
4. Providing education and training needs related to performance improvement; and,
5. Evaluating the overall effectiveness and adjust as appropriate.

Medical Executive Committee (MEC)

The MEC shall be responsible for the ongoing quality of medical care and professional services. In conjunction with the Quality Council, this body shall have responsibility for medical staff improvement and focused review activities. These responsibilities will be accomplished by:

1. Representation and participation on Quality Council;
2. Assessing and analyzing data related to the quality and safety of patient care; and,
3. Involvement by medical staff members in performance improvement activities.
4. Involvement in program evaluation and review.

KEY POSITIONS

Senior Management
Leadership and
Departmental Leadership

RESPONSIBILITIES

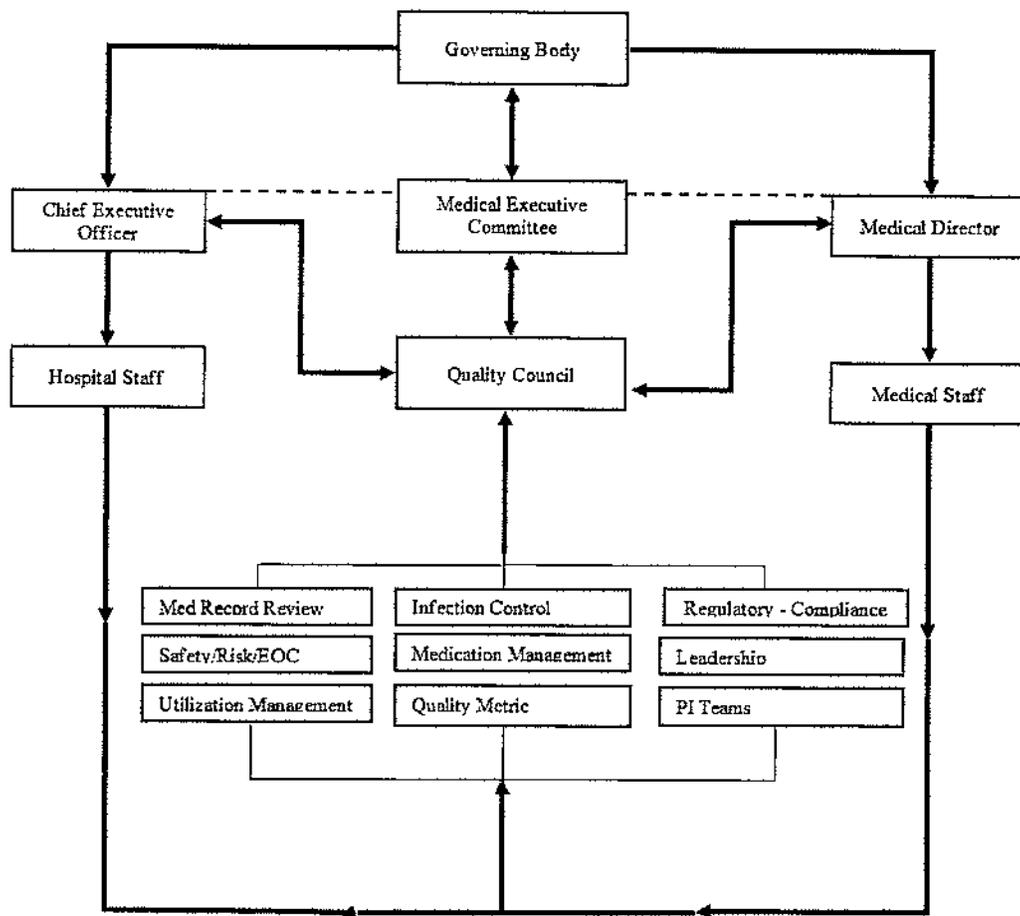
Senior leadership, which includes members of both the administrative and Medical Staff, participate in the Plan as demonstrated through:

1. Development and communication of the organization's strategic goals in conjunction with the Governing Body;

	<ol style="list-style-type: none"> 2. Collection and assessment of pertinent data; and, 3. Supporting the use of internal resources (both human resources and other financial resources) to allow participation and implementation of the Plan in departmental projects and interdisciplinary teams (organizational performance improvement teams). 4. Ensure the implementation of an integrated patient safety program throughout the organization.
<p>Performance Improvement Teams (PI or PIT)</p>	<p>Teams carry out interdisciplinary and complex performance improvement projects as directed by the quality council. These project teams will:</p> <ol style="list-style-type: none"> 1. Follow the approved formats for team projects; 2. Use the adopted performance improvement processes; and 3. Report regularly to the quality council.
<p>All Staff</p>	<p>All staff are responsible for gaining knowledge in organizational performance improvement and participate by:</p> <ol style="list-style-type: none"> 1. Being the eyes of the hospital and looking for opportunities to improve; 2. Participating in their departmental projects; 3. Participating in PI projects; and 4. Communicating to leadership areas identified and recommending possible solutions utilizing the communication mechanisms put in place by the Senior Leadership and Quality Council.

The meeting frequency of the above Committees/teams and their subsequent responsibilities will occur according to the needs of the organization, but no less frequently than required by accrediting bodies and/or the bylaws which govern the Committee, if they exist. Communication of the activities and performance shall occur in both a formal and informal process, but all formal methods will utilize the following structure. The arrows within the representation indicate the two-way communication within the organization.

ORGANIZATIONAL COMMUNICATION STRUCTURE



V. MONITORING AND EVALUATION ACTIVITIES: Processes that must be monitored are as follows.

Topic	Activities
Adverse Drug Reactions	The pharmacist will collect ongoing data and report Adverse Drug Reactions (ADRs) to the Medical Executive Committee at least quarterly <ul style="list-style-type: none"> • Number of ADRs and evaluation of possible causes • Trends, sentinel events
Clinical Outcomes	Patient Outcomes: Wounds, Discharge to Community, Discharge Acute; Discharge LTC, FIM Gain, Length of Stay (LOS), Total discharge FIM, LOS Efficiency. Monthly data collection; report at least quarterly.
Contract Patient Care Services	Patient Care services provided through outside contract service such as Laboratory, Radiology, and others as appropriate reported at least quarterly.
Environment of Care	At least one PI Indicator for each of the seven management plans will be the focus or part of a performance improvement initiative each year. Ongoing Monitoring Hazardous Conditions

	<p>Quarterly Safety Management Reports will be reviewed and forwarded to the Medical Executive Committee including the following area:</p> <ul style="list-style-type: none"> • Safety • Security • Hazardous Materials Management • Emergency Preparedness • Life Safety • Medical Equipment • Utilities
<p>Governing Board</p>	<p>Leaders measure and assess the effectiveness of their contributions to improving performance.</p> <ul style="list-style-type: none"> • The Governing Board will complete a full evaluation of its performance, annually. • The Governing Board will review staff status and competency through the annual hospitalHR Report
<p>Human Resources Staff Competency</p>	<ul style="list-style-type: none"> • The HR Coordinator will review and report staff competency to the Quality Council, MEC and Governing Body through the Competency Review Process form • Identified trends will be utilized to develop educational plans to meet the staff learning needs • Bi-Annual Employee Engagement Survey
<p>Infection Control: Monthly data collection; at least Quarterly report.</p>	<ul style="list-style-type: none"> • Hospital Acquired (HA) infections • Infection Clusters • Trends related to HA infections and/or infection control • MDRO surveillance activities • Employee Health Annual Screens, Immunizations, Illnesses
<p>Medical Record</p>	<p>Medical record review will be conducted on a random sample of charts representing multiple services or programs.</p> <ul style="list-style-type: none"> • Medical Record delinquency rates will be calculated monthly. • PI Indicators as described in the HIM Departmental Plan
<p>Medication Management</p>	<p>Medication management will report to the Medical Executive Committee at least annually.</p> <ul style="list-style-type: none"> • Formulary • Hazardous Medication listing

	<ul style="list-style-type: none"> • Emergency medications • Therapeutic substitutions • Review/Revision of the Look Alike, Sound Alike Drug List • High Alert Medication listing <p>The following are reported quarterly to the Medical Executive Committee.</p> <ul style="list-style-type: none"> • Medication performance improvement • Patient outcomes, trends
Pain Management	The appropriateness and effectiveness of pain management will be followed as a PI in appropriate departments. (Data is collected and reported at least quarterly.)
Patient and family Education	The hospital plans, supports, and coordinates activities and resources for patient and family education
Patient Safety	<p>An organized Patient Safety Program will be ongoing.</p> <ul style="list-style-type: none"> • Select at least one high-risk process for proactive risk assessment (FMEA) at least every 18 months.
Patient Satisfaction (Data is collected ongoing)	<ul style="list-style-type: none"> • Quarterly Reports on patient satisfaction from the Press Ganey will be reviewed with appropriate improvement actions taken as indicated. • Patient's perception of safety will be assessed through the Press Ganey survey and comments.
Focused Review	<ul style="list-style-type: none"> • Medical Staff Focus Review information will be considered in the credentialing process for FPPE, Focused Professional Practice Evaluation, following initial appointment and after trigger events. • Focus Review Criteria (OPPE), Ongoing Professional Practice Evaluation, is reported to MEC and Governing Board at a minimum every six months. • FPPE and OPPE criteria are selected and approved by the MEC.
Restraints Usage	Review of the ongoing use of restraints will be conducted by nursing and reported at a minimum quarterly through the hospital quality structure to include:
Resuscitation	<ul style="list-style-type: none"> • Documentation and process evaluation related to resuscitation of patients, monthly.
Risk Management	<ul style="list-style-type: none"> • Trends, analyses and recommendations for all occurrences involving patients, employees or visitors. • Root Cause Analysis of sentinel event

Utilization Review

- Events that might result in an occurrence which is not consistent with the routine operation of the hospital, such as an evacuation

Patient care monitoring occurs on an ongoing basis. Team conferences are held less than or equal to every 7 days to review all patient progress and to adjust treatment goals/plans. Reports of all conferences are prepared and maintained in the medical record. Problem cases for immediate attention are identified through routine or occurrence monitoring by the treatment team or Case Manager. Additional case selection is based on criteria as outlined in the Utilization Management Plan.

VI. Prioritizing Organizational Performance Improvement Activities

Organizational performance activities and projects are judged and prioritized based on their impact on our customers and the core values of our organization. Activities for consideration are obtained from various customers (internal and external to the organization) including, but not limited to members of the committees listed, hospital employees, Medical Staff members, organizational leaders, referral sources and payers, and the community at large. Information is obtained from the use of the patient grievance/comment system and various types of formal and informal surveys taken during the interview process with customers.

In many instances, a significant improvement in processes can be made without the need for a formalized team. These improvements occur during brainstorming sessions between staff and leaders. These do not require the time that larger projects may entail, but make measurable differences in the operations of the organization. This type of activity is communicated through the hospital quality reporting structure.

Meeting/Records:

Quality Council, Medical Executive Committee and Governing Body meetings are held at a minimum quarterly. Quality Metrics Report (QMR) variance data is reviewed at a minimum quarterly. Performance Improvement Teams report progress at a minimum quarterly. Records of all Quality Council, Medical Executive Committee and Governing Body Meetings activities are maintained. Minutes will reflect recommendations from these groups and any action taken.

Quality Council Membership:

Medical Director or Medical Staff physician representative
 Administrator (CEO)
 Director of Quality Management/ Patient Safety (DQR)
 Chief Nursing Officer and or nursing management representative (CNO)
 Director of Therapy Operations and or therapy leadership representative (DTO)
 Director of Pharmacy Services (DOP)
 Director of Plant Operations (DPO)
 Director of Marketing Operations (DMO)
 Director of Human Resources (HRD)
 Case Management Director (DCM)
 Controller (CFO)
 Infection Control Preventionist/ Employee Health Nurse
 Dietician
 Other Department Representatives and Contract Services as needed

VII. Education and Training

All employees are educated regarding performance improvement upon initial orientation and annually at re-orientation processes. Education encompasses the performance improvement methods, input into performance improvement activities, and responsibility for the continued improvements within the organization.

VIII. Monitoring, Collecting, and Analyzing Data

Data is the foundation of performance improvement activities. Data alone is insufficient to improve the performance of the organization. A process for data use is required. This process includes:

- planning
- collection
- assessment/analysis
- actions

1. Data planning involves the determination of appropriate data that will effectively measure the process/outcome that has been prioritized. The planning of data collection should be timely at intervals that allow for effective assessment, conclusions, and recommendations.

2. Data collection objectively measures the processes and indicators. Measurements are made to accurately assess the outcomes and must be defined. Method for collection, resource for data, and the formula for data calculation must be documented in order to compare the impact of the process change.

3. Data assessment and analysis must be performed in order to utilize the data as information that allows the organization to make informed decisions regarding changes in culture, processes, patient care, and performance of business functions.

4. Actions based on the data and information obtained is planned in order to improve the performance of the organization. These actions are planned by the department, team, or organizational structure identified as responsible for the improvement. National Clinical Practice Guidelines and evidence based practices is considered when developing improvement strategies.

Data utilized by the organization is obtained from internal and external sources. Comparison data is desirable in all measurement functions in order to determine the appropriate level of operation. Data measurement and analysis over time determines the ability of the process to succeed in all circumstances.

Opportunities for performance improvement may be identified by the systematic review of the internal and external data obtained by the organization. Measurements that fall below the acceptable expectations and thresholds typically indicate an opportunity for improvement. Additionally, data may indicate acceptable levels, but may not necessarily suggest optimal efficiency and effectiveness. The organization has many data sources that may include, but is not limited to the following:

Quality of Care

Patient outcome data

1. Uniform Data System (UDS) data reports (external)
2. Hospital Risk Management Event Reporting (internal)
3. Clinical Department measurements (internal)
4. Patient Accounting Systems reports (internal)
5. Patient Outcome Management Systems (internal)
6. The Joint Commission /CMS/State Survey Reports (external)

Patient satisfaction data

1. Press Ganey quarterly report (external)
2. Complaints and Grievance Process (internal)

Financial Management

1. Patient Accounting Systems reports (internal)
2. Income Statement (internal)

Compliance

1. Internal and External Audit Reports
2. Patient Outcome Management Systems (internal)
3. Corporate Compliance Hot Line (internal).
4. The Joint Commission/CMS/State Survey Reports (external)

Human Resource Management

1. Employee Health data (internal)
2. Human Resources Reports (internal)
3. Payroll Records (internal)

Volume Growth

1. Patient Accounting Systems reports (internal)
2. Patient Outcome Management Systems (internal)
3. Patient Medical Records (internal)

VIII. Department Involvement

In order for the organization performance plan to be effective, it must be supported by the department specific activities. The performance improvement process is both organization wide and department specific. The plan not only represents a hospital wide approach to performance improvement; moreover, it dictates the need for each department to assess its role in the organization's strategic plan. Each department must assess its customer, their needs and expectations, and gauge its ability to meet these needs through objective measurements. Reports of significant findings, activities, and actions will be reported through the hospital quality structure.

IX. Plan Effectiveness

On an annual basis, the plan will be assessed for its impact on the organization's improvement within the strategic goals developed. This assessment is based on several objective measurements including:

1. Financial indicators
2. Functional indicators
3. Measures of customer satisfaction
4. Improvements directly related to performance improvement teams

Close

Spring Mountain Treatment Center
2019 PERFORMANCE IMPROVEMENT PLAN
2018 ANNUAL EVALUATION

During this period, the Performance Improvement Plan (PIP) focused on the important functions and processes of the organization to improve the quality of patient care, patient safety, and patient outcomes and to enhance the value of our services and to improve our operational efficiency. The goal of the PIP is to provide a framework and motivation for improvement of patient health outcomes and customer satisfaction by design of effective, organization-wide processes followed by measurement, assessment, and improvement of those processes.

Priorities for improving our systems and processes were based on our high risk, high volume, and problem prone processes and their outcomes such as:

- Seclusions and Restraints
- Standards Compliance
- Patient Grievances
- Patient Rights
- Treatment Plans
- Assessments of Patients
- Emergency Transfers
- Medication Safety
- Patient Safety
- Infection Prevention
- Discharge Planning
- Patient/Family Education
- Patient/Family Satisfaction
- Documentation
- Continuum of Care and Partial Hospitalization
- Community Needs
- Utilization Management
- Safety and Risk Management
- National Patient Safety Goals
- Sentinel Events and Root Cause Analyses
- Failure Mode Effects Analysis
- Performance Improvement Benchmarking
- Environment of Care
- Health Information Management
- Employee Surveys/Staff Retention
- Referral Source Satisfaction
- Staff Competency
- Contract Services
- Safety Culture Survey
- Hospital Based Psychiatric Inpatient Services (HBIPS) for Joint Commission

The Scope of the PIP included activities from the following structures:

- Direction and support from the Governing Board regarding policies, organizational management and planning.
- Participation from the Medical Staff in activities which measure, assess, and improve performance on an organizational-wide basis and by attending medical staff meetings.

- Direction and support from the Medical Executive Committee, action on reports from the medical staff committees and communication to the medical staff members.
- Direction and support from the leadership of the facility in the planning, implementation, coordination, and improvement of services.

Prioritization of Performance Improvement activities and monitoring of indicators:

- All indicators identified for monitoring will be based on ensuring patient safety and potential for risk to patients.
- Frequency/duration of monitoring and reporting will be determined by level of risk and compliance with benchmark set by Quality Council and approved by MEC and Governing Board.
- Indicators tracked and trended through the Performance Improvement process will be prioritized based on the results of the below performance improvement activities
 - Highest Risk
 - Results from FMEA and AMSR implementation
 - Review of incident reports which identify trends which pose a high risk to patient safety
 - Medium Risk
 - Regulatory/state requirements
 - Lower Risk
 - Indicators found to be non-compliant
 - Lowest Risk
 - Statistically stable indicators

Evaluation of Activities

- The PI Committee continued to evaluate current practice and policies related to Joint Commission Standards. The Committee reviewed the results of the FSA and reported on Corrective Action Plans.
- Benchmarking on key clinical indicators within the division continued throughout 2018. Data collected continued to be reported showing rates per 1000 patient days and comparisons over time.

The UHS Dashboard was reviewed monthly in PSC and corrective action plans were created for indicators that trended above the UHS benchmark and/or UHS average score for that month. While the indicator for falls will be to continue be monitored, the focus will be working towards ensuring the suicide risk assessment is fully and accurately completed to ensure patient safety. The PSC will review and accept the FMEA once all action items are complete.
- Seclusion and Restraint rate goals for 2018 were made and rates were benchmarked. Rates were determined per 1000 patient days.

The overall physical hold rate and the overall seclusion rate for 2018 were below trend and below prior year for the entirety of 2018. The indicator will be monitored monthly with the goal of having both indicators below benchmark in 2019.
- The hospital medication safety plan encourages all staff to report medication issues in a non-punitive environment. Nurses are actively involved in reporting potential medication variances and provide recommendations to improve our processes to prevent errors.

Nursing Leadership revised the medication audit and process again in 2017. The PI Committee and PSC will monitor for the effectiveness of the audit in 2018.

- The PI Council continues to review the effectiveness of the fall prevention program.

The Patient Safety Council focused on decreasing Seclusion and restraint as the primary initiative in 2018. A PIT was created to focus on revising the behavior medication plans, 1:1 staffing and interventions that emphasized non-physical interventions. The PSC focused on improving patient education and collaboration as a means to prevent restraints/seclusions, created FMEA based on that goal, and revised the 1:1 behavior plans and protocols to include a targeted, refined debriefing component

- Joint Commission's Hospital Based Inpatient Psychiatric Studies (HBIPS).
HBIPS-1: Assessment of violence risk, substance use disorder, trauma and patient strengths completed.

Remained at an average of 100% compliance throughout the year.

HBIPS-2: Hours of restraint use.

Remained below the UHS average.

HBIPS-3: Hours of seclusion use.

Remained below the UHS average.

HBIPS-4: Patients discharged on multiple antipsychotic medications.

Remained below the UHS average.

HBIPS-5: Patient discharged on multiple antipsychotic medications with appropriate justification.

This area significantly improved in 2018.

HBIPS-6: Post discharge continuing care plan created.

Remained at an average rate of 100% compliance throughout the year.

HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge.

Remained at an average rate of 100% compliance throughout the year.

SUB-1: Alcohol Use Screening. Met the goal of 90% or better compliance and was at 94% in Q4-19.

TOB-1: Tobacco Use Screening - This indicator was added in 2015 and in Q4-15, the Facility scored at 95%

TOB-2: Tobacco Use Treatment Provided/Offered - This indicator was added in 2015 and in Q4-15, the Facility scored at 100%.

TOB-2a: Tobacco Use Treatment Provided – This indicator was added in 2015 and the Facility scored at 100% in Q4-19.

IMM-2: Patient Influenza Vaccination – This indicator was added in October 2015. December 2018 the Facility was almost 90% compliant.

- Human Resources studies in conjunction with Risk Management reviewed staffing effectiveness, competency, recruitment and retention.

The turnover rate decreased toward the end in 2018. Staffing effectiveness is reviewed monthly via the incident reporting system, RCA analysis, and review of Good Catches. In 2019, the UHS Corporate Loss Control representative will continue to assist in reviewing all incidents and determining if there are staffing related concerns.

- Patient Grievances will be reviewed by the PI Council, Medical Staff, and the Governing Board.

The process was revised in 2017 and continued the process through 2018 to encourage staff to address patients' concerns directly instead of

the patient waiting to speak with the PA. This resulted in a significant decrease in Grievances and the Facility again met the goal of less than 5 grievances per 1000 patient days.

- Patient and Family Education indicators identified opportunities to improve multidisciplinary education.
Improving education was a large focus in 2018. Additional educational handouts were created, more booklets ordered. Implementing more education on behavior medication plans, 1:1 staffing and interventions that emphasized non-physical interventions was an area of focus in 2018. Education included staff and patients. Staff were provided an opportunity to participate in focus groups, Performance Improvement Teams related to the admit flow, and trainings on restraint and seclusion reduction as well as managing patient aggression.
- Sentinel Event Alerts were reviewed, RCAs were completed as required, and a Failure Mode Event Analysis was completed.
A FMEA was completed for patient restraint/seclusion. Several items were implemented due to the FMEA results. These items included the following: A PIT was created to focus on revising the behavior medication plans, 1:1 staffing and interventions that emphasized non-physical interventions..
- The 2018 National Patient Safety Goal changes were implemented and continuous monitoring of our compliance with previous Safety Goals was maintained.
Facility ensured all NPSG were complied with as well as provided staff education on changes and revisions.
- Health Information and documentation requirements were monitored through a comprehensive retrospective clinical chart audit system. The audits include patient rights, medication management, assessments, treatment plans and discharge information. All findings were presented in numerical and graphs formats with quarterly findings, action plans and effectiveness of activities.
The Audit Tool was revised based on the Facility's current needs. Treatment Planning documentation continues to be an area with room for improvement. The DCS and CNO conducted multiple hospital wide trainings on proper completion of the treatment plan in 2017.. This emphasis continued in 2018. Compliance with B tags were heavily trained on and audited for in order to ensure compliance.
- Performance Improvement Teams were organized and active to improve patient care.
The PIT for R/S reduction met 5 times in 2017 and 8 times 2018 until all agenda items are implemented.
- Outpatient Services monitored the continuum of care, attendance and referral rates, as well as patient satisfaction.
Patient satisfaction in Outpatient remains high, however return rates remain lower than goal. The OP Director will be revising the process for collecting surveys in order to increase the return rate. Outcomes measures were implemented to monitor patient improvement

Goals for 2019

- Continue to identify changes that will lead to improved performance and reduce the risk of sentinel events.
- Maintain compliance with Joint Commission Standards by continuously monitoring performance comparative to updated requirements.
- Analyze and improve on the outcomes related to HBIPS indicators by comparing results to company and national benchmarks in the PI Committee. Implement the new HBIPS indicators for Tobacco and Alcohol Use. Ensure case managers are SBIRT trained so they can provide Brief Interventions. 100% compliance was achieved by middle of 2018. Implement the new indicators that are being released mid-year.
- Maintain the achievements of our performance improvement activities and continue to improve these processes, functions or services.
- Maintain compliance with all National Safety Goals. Re-educate staff on an ongoing basis regarding high risk issues.
- Reduce occurrences of restrictive interventions, falls, and medication variances.
- Complete a FMEA and develop action plans aimed at the goal of compliance.
- Conduct Security drills in main building and off-site locations.

LIFE SAFETY MANAGEMENT PLAN

I. Scope of Plan

The Desert Orthopaedic Center Surgery Center (DOCSC) administration and governing body are strongly committed to providing a safe and secure environment for patients, visitors, staff and property. The Life Safety Management Plan is the basis for managing the environment of care, including infection control, security, hazardous materials and wastes, emergency preparedness, and utility systems in a fire-safe environment and in accordance with applicable codes and regulations. This plan is reviewed annually.

II. Objectives

DOCSC strives to protect patients, visitors, staff, and property from infection and environmental hazards by meeting the following objectives:

- ✦ Prevent and control infections within the facility through the implementation of effective and nationally recognized infection control policies.
- ✦ Ensure proper operation of fire detection, alarm, and suppression systems through a program of regular inspection, testing, and maintenance.
- ✦ Provide portable fire extinguishers according to established criteria for type, placement, inspection, maintenance, and use.
- ✦ Ensure acquisitions such as curtains, furniture, waste baskets, and other equipment meet established fire safety criteria.
- ✦ Collect information on staff knowledge and skill during drills.
- ✦ Evaluate staff and equipment response during fire and facility emergencies.
- ✦ Ensure facility code compliance to identify and correct deficiencies.
- ✦ Provide fire safety orientation for new employees and quarterly thereafter.
- ✦ Provide for specific roles and responsibilities of personnel at the fire, at areas away from the fire and during evacuation.
- ✦ Establish a risk-assessment program that proactively evaluates the building, grounds, equipment, occupants, and internal physical systems and their potential impact on patient and public safety.

- ✦ Establish an emergency preparedness program designed to manage the consequences of natural disasters or other emergencies that may disrupt the facility's ability to provide care.

III. Standards of Performance

- ✦ All staff complete training in infection control, including aseptic technique and standard precautions, annually.
- ✦ Fire drills and education are conducted every quarter
- ✦ Staff will know locations of fire extinguishers and alarms
- ✦ Evacuation routes are posted in the facility
- ✦ Orientation and continuing education of the staff
- ✦ Management of hazardous materials and waste
- ✦ Bomb Threat drill and education twice a year
- ✦ Internal / External disaster at least twice a year

IV. Information Gathering and Reporting

The DOCSC Safety / Quality Improvement Committee is represented by administration, and clinical and business office staff. The committee will meet at least monthly.

Information regarding worker knowledge about life safety and the fire protection system is gathered during fire drills and safety rounds.

Performance improvement and trends are submitted to the Medical Executive Committee and Governing Body.

V. Organizational Roles and Responsibilities

The administrator and department supervisors have direct authority and responsibility for both the safe actions of employees and the safe performance of equipment within their department. Administration and the department supervisors shall:

- ✦ Ensure adherence to infection control policies and procedures not limited to, but including, the proper use of required personal protective equipment, aseptic technique, high level disinfection and sterilization.
- ✦ Take appropriate disciplinary action when safety rules are violated.
- ✦ Take prompt corrective action whenever unsafe working conditions are observed and report them to administration.
- ✦ Thoroughly investigate and report all accidents and take appropriate action(s) to prevent re-occurrence. All accidents shall be investigated, including those which do not result in injury or illness.
- ✦ Inform employees of the safety committee activities.

- ✦ Critique staff response during scheduled fire drills and emergency preparedness drills.
- ✦ Assess security and risk and make appropriate adjustments.

Each employee is responsible to practice safety on the job for themselves, patients, visitors, and other employees. Therefore each employee shall:

- ✦ Adhere to infection control policies and procedures not limited to, but including, the proper use of required personal protective equipment, aseptic technique, high level disinfection and sterilization.
- ✦ Report unsafe conditions to the department supervisor whenever a safety hazard or unsafe condition is identified.
- ✦ Promptly report all injuries and lost days due to work injuries or illness to the department supervisor.
- ✦ Use only equipment in safe operating condition. Tag and report defective equipment promptly.
- ✦ Respond to emergency situations in accordance with facility policies and procedures.

VI. INDICATORS AND THRESHOLDS

Continuing Safety Education and Training

- ✦ All new personnel are oriented to the Safety Management Program. Threshold 100%.
- ✦ All personnel participate in continuing safety education and training at least annually. Threshold 100%.

Hazardous Materials and Waste

- ✦ Proper storage of hazardous material. Threshold 100%
- ✦ Proper waste disposal equipment available. Threshold 100%
- ✦ Proper handling of hazardous material. Threshold 100%
- ✦ Fire drills conducted quarterly. Threshold 100%

Emergency Preparedness

- ✦ Drills are conducted semi-annually. Threshold 100%

Fire Safety

- ✦ Fire drills are conducted quarterly. Threshold 100%
- ✦ Portable fire extinguishers checked annually. Threshold 100%

Equipment Management

- ✚ Scheduled preventive maintenance is performed on patient equipment. Threshold: 100%.
- ✚ A summary of equipment problems / failures is immediately reported to the safety committee. Threshold 100%.

Security

- ✚ All theft and vandalism is immediately reviewed.

Performance Improvement

- ✚ A summary of actions taken by the performance improvement committee is reported quarterly. Threshold 100%

VII. DATA COLLECTION

Quality Indicator data, including patient care and other relevant data regarding furnished services, shall be incorporated. The data are used to monitor the effectiveness and safety of services and quality of care rendered. The data results will help identify opportunities to change and improve patient care. Data sources include:

- ✚ Incident Trending Report
- ✚ Infection Trending Report
- ✚ Patient / family / vendor complaints
- ✚ Patient Satisfaction Surveys
- ✚ Quality Assurance Committee findings

VIII. EVALUATION OF PLAN ACTIVITIES

DOCSC sets priorities for Quality Improvement activities that

- ✚ Focus on high risk, high volume and problem prone areas
- ✚ Consider incidence, prevalence and severity of problems in those areas
- ✚ Affect health outcomes, patient safety and quality of care

QI activities shall track adverse patient events, examine their causes, and ensure implemented improvements are sustained over time.

DOCSC shall implement preventive strategies throughout the facility, targeting adverse patient events and ensuring all staff members are familiar with the strategies.

IX. CORRECTIVE ACTION

The safety committee and other committees shall implement a corrective action and follow up for each indicator, as warranted.

X. ASSESS ACTIONS AND DOCUMENT IMPROVEMENT

The Safety / Quality Improvement Committee will oversee the effectiveness of corrective action and the progress toward problem solving resolution. The findings, conclusions, recommendations and follow-up will be reported to the medical executive committee and the governing board.

QUALITY IMPROVEMENT, RISK MANAGEMENT, AND
PATIENT SAFETY PLAN

NAME-OF-CENTERSPECIALTY SURGERY CENTER
2019

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Revised 12/26/2018

The mission of ~~(Center name)~~Specialty Surgery Center is focused on delivering the highest quality, cost effective healthcare that effectively responds to the needs and safety of our patients by minimizing the possibility for injury or harm to our patients. We are committed to the care, dignity and improvement of human life to the patient populations we serve.

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In keeping with the mission of ~~the~~ ~~(Center Name)~~Specialty Surgery Center, the community, HCA initiatives, and regulatory standards for ambulatory surgical care, this plan allows for a planned, systematic, organization-wide approach to the quality improvement process, and ~~–~~assessing opportunities to reduce risk. This is accomplished through an effective risk and quality program, as well as, a medication and radiation safety plan that are all targeted toward improving patient safety. The activities will be carried out in a collaborative and interdisciplinary manner. When identified, individual competency issues and process changes will be coordinated with the management team and human resources. The overall strategies of the program include

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- Improving patient safety and reducing risk to patients which includes, but not limited to medication and radiation safety, safe quality care and reducing risk of injury to patients and staff;
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety;
- Assuring that quality improvement initiatives continue to focus on high priority areas of clinical care, monitoring of process and outcome indicators; redesigning processes and systems and providing education to foster improvement;
- Positioning ~~Center Name~~Specialty Surgery Center to achieve earning expectations and maintain effective cost-containment strategies while providing high quality of patient care, and
- Meeting the expectations of the HCA internal initiatives, as well as, the external regulatory agencies and accrediting bodies through the identification of opportunities to improve patient care, demonstration of appropriate action taken, and follow up on the effectiveness of action taken.

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Strategies will be incorporated in each of the following areas to identify opportunities and set goals to achieve and sustain the desired results in striving to become a high reliability organization (HR):

- Performance Improvement Processes
- Quality studies
- Risk Management Strategies
- Patient Safety Initiatives
- Infection Control Strategies
- Medication Safety Strategies
- Radiation Safety Initiatives

HCA Patient Safety Organization (PSO), LLC

HCA established a Patient Safety Organization, LLC in spring of 2014 in accordance with provisions of the Patient Safety and Quality Improvement Act (Public Law 109-41). The PSO is a component of its parent entity, HCA. The mission of the PSO is to conduct activities to improve patient safety and the quality of healthcare delivery. The vision is to assist participating providers in the elimination of preventable patient harm. The activities of the organization include:

- Improve patient safety and the quality of health care delivery
- Collect and analyze Patient Safety Work Product (PSWP)
- Develop and disseminate information regarding patient safety
- Utilize PSWP to encourage a culture of safety and provide assistance to effectively minimize patient risk.
- Maintain procedures to preserve confidentiality and provide appropriate security of PSWP
- Utilize qualified medical personnel
- Operate a patient safety evaluation system (PSES) and provide feedback to participants of the PSO
- Utilize the Serious Event Analysis (SEA) process to identify the root causes of serious patient adverse events, per policy.

~~(Center Name)~~ Specialty Surgery Center is a member of the HCA Patient Safety Organization (PSO), LLC.

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The Administrator -serves as the designated PSO Contact and oversees all activities of the PSO for the center, while the Risk/Quality Manager shall serve as the Contact Designee. The Center will provide patient safety work product (PSWP) documents as requested by the PSO. The center will receive information from the PSES to evaluate opportunities for improving patient safety and quality care. All information submitted will remain confidential within the PSO.

Quality Improvement Plan

The Center maintains an ongoing quality improvement program that has a broad scope to address administrative, clinical, and cost effective performance. The program also addresses patient outcomes, patient care processes, as well as, medication, radiation and patient safety. Elements of the program include, but are not limited to a

- Written plan that addresses the scope of health care services provided by the Center and how the quality improvement plan for these services are assessed.
- Interdisciplinary QI committee for the development, implementation, review and oversight of the program. The committee has administrative, clinical and physician participation.
- Set goals and objectives that are reviewed and updated at least annually.
- Quality improvement activities such as audits and studies to identify problems with processes or patient care. The studies will be done utilizing the ten (10)-step process that is encouraged by the Accreditation Association for Ambulatory Healthcare (AAAHHC).
- Measurement of data against internal and external benchmarking sources.
- Annual reviews of the effectiveness of the program.
- Periodic reports to Governing Body that encompass a summary of the quality improvement activities, findings and process changes if indicated.

Risk Management and Patient Safety

Definitions of Potential Risk Issues

Event: A discrete, auditable and clearly defined occurrence (**National Quality Forum**).

Occurrence: The action, fact, or instance of something that happens synonymous with an event;

An event, situation, or process that contributes to, or has the potential to contribute to, a patient or visitor injury, or degrade our ability to provide optimal patient care. Reportable occurrences can generally be divided into the following types based on severity: Sentinel events, patient and visitor injuries, [adverse events], near misses (close calls, good catches etc.), and safety concerns. (**National Patient Safety Foundation**.)

Incident: Synonymous with occurrence or event. An occurrence or event that interrupts normal procedure and can precipitate an untoward or unplanned outcome an unusual event that occurs at the facility, such as an injury to a patient. Involved damage that is limited to parts of a unit, whether the failure disrupts the system or not. (NPSF). A patient safety event that reached the patient, whether or not the patient was harmed (NQF).

Adverse Event:

A patient safety event that resulted in harm to a patient. (The Joint Commission, 2018).

Any injury caused by medical care. Examples:

- o pneumothorax from central venous catheter placement;
- o anaphylaxis to penicillin;
- o postoperative wound infection;
- o hospital-acquired delirium (or "sun downing") in elderly patients.

Identifying an event as adverse does not imply "error," "negligence," or poor quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis, treatment or therapy, as opposed to an underlying disease process. Thus, pneumothorax from central venous catheter placement counts as an Adverse Event regardless of insertion technique. Similarly, postoperative wound infections count as adverse events even if the operation proceeded with optimal adherence to sterile procedures and the patient received appropriate antibiotic prophylaxis in the perioperative setting. (Agency for Healthcare Research and Quality, Patient Safety Network- AHRQ, PSNet)

Sentinel Event: A Patient Safety Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel Events are a subcategory of Adverse Events. (The Joint Commission, 2018).

n adverse event in which death or serious harm to a patient has occurred, usually used to refer to events that are not at all expected or acceptable—e.g., an operation on the wrong patient or body part. The choice of the word sentinel reflects the egregiousness of the injury (e.g., amputation of the wrong leg) and the likelihood that investigation of such events will reveal serious problems in current policies or procedures. (Agency for Healthcare Research and Quality PSNet)

Serious Patient Adverse Event or SPAE: A Patient Safety Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and may result in any of the following:

- Death
- Permanent harm
- Severe temporary harm, or risk thereof

Such an event may result in patient injury as well as cause damage to the Facility and/or HCA's reputation as well as the Facility's accreditation, certification or licensure.

Close Call (Near Misses/Good Catches): Events or situations that could have resulted in an adverse event (accident, injury, or illness), but did not, whether by chance or through timely intervention. Such events have also been referred to as "near miss" incidents. An example of a close call would be a surgery or other procedure almost performed on the wrong patient due to lapses in verification of patient identification, but caught prior to the procedure (Source: VA Patient Safety Program).

Serious Event Analysis (SEA): A method of problem solving that attempts to identify the root causes of a process or processes. The SEA process tries to evaluate the underlying "whys" for the variances and solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing on the correction of root causes, problem recurrence can be prevented. An analysis is done *after* an event has occurred. All staff members involved, as well as, the Risk Manager and physicians involved shall participate in the SEA analysis The SEA process is typically used as a reactive method of identifying event(s) causes, revealing problems and identifying opportunities to reduce the risk of future occurrences. The SEA action plan is reported at the quality meetings, MEC and GB meetings.

Risk Management

The Center maintains an ongoing risk management program designed to protect the life, safety and welfare of the patients and employees. Risk management addresses strategies from the organizational, operational, human resource and liability areas of the organization. Goals of the program may include, but are not limited to:

- Improving patient safety and reducing risk to patients;
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety
- Reviewing and tracking of variance reports and litigations for trends.
- Reviewing and tracking of adverse outcomes, near misses (close calls) or sentinel events to identify gaps or opportunities for improvement.
- Maintaining a strong credentialing and privileging process and current bylaws that meet community standards
- Keeping abreast of current standards for risk management and adapting practice and policies that are compliant with standards.

It is evident through the goals, activities and processes that the quality improvement and risk management programs intertwine and cross all spectrums of the organization. Quality care, as well as patient and employee safety is at the center focus of both programs. The operational linkage between Risk management, Safety, Quality and Infection Control is accomplished through the following mechanisms:

- Issues or trends identified through chart reviews, peer reviews, safety, radiation and infection control rounds are discussed and referred to the appropriate department for evaluation and/or corrective action
- Data from variances that identified trends, adverse events or any events that impact the quality or safety of patient care will be reviewed and referred to appropriate risk and leadership personnel for investigation, analysis and corrective action
- The Risk manager will review current issues and risk reduction strategies with appropriate personnel and develop a plan of action. This will be reported to MEC/GB.
- The Quality Committee will serve as the oversight committee for Patient Safety, Risk Management, Infection Control. Medication Safety and Radiation Safety fall within a subsection of the Quality Committee and will be addressed as indicated.

These plans engage active involvement of all members of the healthcare team, as well as patients, families and physicians, addressing an environment which:

- Encourages recognition and acknowledgment of opportunities to improve quality performance and to reduce risks to patient safety,
- Initiates actions to improve processes or reduce these risks,
- Encourages internal reporting of what has been found and the actions taken;
- Focuses on processes and system,
- Minimizes individual blame or retribution for involvement in a medical/health care error; and
- Challenges leaders of the organization to be responsible for fostering a “non punitive” culture of continuous improvement, reducing risk and creating a safe environment for patients, employees and physicians.

Medication Safety

A designated pharmacist (consultant or regional HCA) oversees the medication practices and processes at the Center. Their duties include, but are not limited to

- Conducting medication rounds and audits providing feedback on areas of opportunities. This includes validation of medication safety practices.
- Adhering to strict processes for ordering, administration and tracking of controlled substances.
- Collaborating with the Center on choice of pharmaceutical vendors and formularies
- Collaborating with the Center on policy review and development

- Participating in review of any medication error or diversion
- Assuring controlled substance ordering and monitoring is in accordance with state and federal regulations

All relevant activities are reported through QI/MEC/GB.

Radiation Safety

This facility utilizes radiation emitting equipment and therefore, by direction of the Governing Body/Board. Radiation Safety will be a subgroup of representatives to be included under the QI/Safety/Risk committee to report radiation safety activities. Key activities are established by the Radiation Right policies identified as CSG.MI.001 Governance and CSG.MI.003 Fluoroscopy:

- Designate an individual that is approved by MEC/GB to oversee the program
- Oversee ongoing measurement, periodic review, and improvement of key radiation safety practices and provide a quarterly report to the QI/Risk/Safety committee (Quarterly rounds)
- Periodic maintenance of equipment
- Maintaining and reviewing exposure time logs
- Communicate relevant radiation safety activities, as necessary, to the staff.
- Serve as a resource for radiation safety as it relates to staff and patient safety/regulatory issues and for the regulatory component of accrediting agencies.
- Educate staff on radiation safety practices

Infection Control

The Center conducts an annual infection control risk assessment in order to identify areas of opportunities to reduce the risk of infections (Refer to Infection Control Plan, IFC). All activities are reported through QI/MEC/GB.

Peer Review Ambulatory Surgery Centers are required by AAAHC, CMS, and other regulatory agencies to conduct quality improvement and peer review on medical staff members and allied health professionals. Peer review activities include ongoing, specialty specific review and review of variances. Peer Review will be conducted in accordance with the peer review policy and medical staff bylaws.

Confidentiality

All quality improvement and peer review activities and data are considered confidential. Any requests by outside sources for any QI, Risk management, Peer Review or credentialing information or reports will be forwarded to the appropriate HCA administrative/corporate staff when indicated.

ORGANIZATION STRUCTURE AND PROCEDURE

Role of Leadership

Leaders play a key role in facilitating improvement and ensuring a safe environment. The ~~(Center name)~~ Specialty Surgery Center leadership includes the Governing Body, Medical Executive Committee; the facility based Medical Directors, Administrators, Risk/Quality/Safety/Radiation Safety/Infection Control designees and Clinical Managers. Leaders foster quality improvement through planning, educating, setting priorities, providing support such as time and resources, and empowering staff as appropriate.

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Governing Board/Medical Executive Committee

The Board has the ultimate authority and accountability for the quality and risk programs to ensure that the quality of patient care is provided in an efficient, safe, timely and cost-effective manner. The Governing Body provides support for the improvement strategies and delegates to the Medical Executive Committee and leaderships at each facility, the authority to perform assessment and improvement activities through committees and teams. Quarterly, the Governing Body shall receive a report on the activities of the quality and risk management programs. These functions include, but not limited too:

- Assure QI/Risk/Radiation/Medication/Patient Safety is an integral part of the Center's objectives, plans and management structure
- Provide resources to support the QI/Risk/Patient Safety programs.
- Assure that improvements are sustained and evaluated for effectiveness
- Review and approve policies, reports, QI/Risk/Safety/IFC data collection and analysis, the QI/Risk/Patient Safety plans and annual evaluation.

Administration

The Center Administrator is responsible for providing qualified personnel to support the proper functioning of quality improvement and risk management activities. Administration will participate in performance improvement activities and in the assignment of priorities to the functions identified by performance improvement activities.

Key Goals:

- Assure patient care is delivered safely
- Ensure the ongoing competencies of the staff
- Support an environment that promotes process improvement, quality outcomes, reduction in risk, patient and employee safety and customer satisfaction
- Oversee reviewing and keeping current with regulatory standards (CMS,CDC, state and AAAHC)

Key Activities:

- Develop specific goals, objectives, and targets for quality improvement, risk management, infection control, as well as, radiation/medication/ patient safety.
- Designate responsibility to qualified individuals or an interdisciplinary committee for ensuring that quality and risk goals/objectives, as well as patient safety are achieved.
- Provide adequate time and training, as well as resources, for personnel to participate in quality improvement activities and to improve patient safety.
- Assure clear systems and policies/procedures for internal and external reporting of information relating to performance indicators/measures and medical/health care errors.
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors. Actively encouraging all staff to identify and report hazardous conditions and errors in a blame-free environment.
- Establish or supporting changes in processes, functions and services to sustain improved performance and to prevent recurrence and reduce risk to patients.
- Assure the effectiveness of the quality and risk management goals/objectives and contributions to improving patient safety are measured and assessed annually.

Quality Improvement/ Risk/Infection Control/Radiation Safety/Medication Safety/Patient Safety

Committee

Each facility has a quality improvement committee, which derives goals from the Governing Body, Medical Executive Committee, Administration, staff and other sources. Primary responsibility of this committee is to maintain a culture of patient safety throughout all patient care processes and organizational functions. This committee is interdisciplinary and includes, but not limited to the QI/Risk/IFC Manager, Facility Administrator, Medical Director and Clinical Managers. Other members such as supervising radiologist, pharmacy nurse etc will be added to the committee as indicated by the agenda. The committee is designed to provide upper management support and direction for improvement efforts.

Key activities:

- Establish and oversee ongoing measurement, periodic review, and improvement of key processes
- Assist in identifying opportunities for improvement and participate in QI studies.
- Participate in Ambulatory Surgery Division quality, risk and patient safety initiatives including Best Practices
- Communicate relevant activities, as necessary, to the staff.
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors

- Serve as a resource for patient safety/regulatory issues and for the regulatory component of accrediting agencies.
- Provide periodic reports on quality improvement activities to Medical Executive Committee and Governing Board.
- Educate staff on quality, risk and patient safety activities

Quality Studies

Quality studies will reflect the scope of services, priorities and findings from performance monitoring or other sources. Studies will address clinical, administrative, and/or cost of care issues and will be documented in the (10) step format, which includes:

- State the purpose of the process improvement opportunity/purpose of the study
- Identify the goal of the study
- Description of data to be collected and established criteria
- Evidence of Data Collected
- Data analysis
- Comparison of actual data to goal
- Development of corrective action and execution timeline
- Re-measurement and monitoring to determine if actions have been achieved and improvements are sustained
- Development of additional corrective actions if needed
- Communication of results to appropriate personnel, MEC and Governing Board

Staff Education

The staff receives an orientation on quality improvement, risk management, infection control and patient/employee safety initiatives within 30 days of employment as part of new employee orientation. At least annually, a review of the process and accomplishments will be conducted through an appropriate mechanism. Clinical leaders will receive periodic training on any updates to initiatives, new statistical reporting or other information as indicated.

Ongoing Measurement

The Quality/Risk Manager in collaboration with the Facility Administrator and Medical Director oversees ongoing measurement. These are outlined on the addendum to this plan.

Design of New Processes

When the Center is considering a new process (for example, providing a new patient service, constructing a new facility, or redesigning an existing service), a multidisciplinary team will be convened to ensure that the process considers:

- The organization's mission, vision and strategic plans;
- Patient and community needs;
- Information about performance and outcomes of the process (including information from reference data bases).
- Current evidence based practice and research
- Current regulatory standards

Periodic Assessment and Improvement

Based on ongoing review of measurement data, this plan provides for assessment of data against historical trends and available benchmarks whenever possible. The Quality Committee, Medical Executive Committee and Governing Board review all measures quarterly.

Assessment may be triggered for any of the following:

- By any sentinel event;
- By important undesirable single events, which may include:

- "Near miss" events
 - Significant injury or death
 - Any significant untoward event during moderate sedation or anesthesia;
 - Any serious adverse drug or medication error event; and
 - Any significant hazardous condition.
 - Any significant infection control breach or trend
- By important undesirable patterns or trends, which may include:
 - Staffing effectiveness or clinical issues;
 - Any quality measure that varies substantially from an expected range; and
 - When the organization's performance significantly varies below that of other ambulatory surgery settings or recognized standards.

Select quality data is submitted to HCA and trended with internal benchmarks across the company. This information is shared at the facility, division and enterprise level. This information is used to develop division and enterprise wide quality and risk initiatives and for external benchmarking in the ambulatory surgery arena.

In addition to ongoing measurement, the Center may at any time proactively assess its culture of patient safety as well as specific processes of care that have been identified within the healthcare industry as having the potential to harm patients. The Center may periodically assess processes using tools provided from a variety of outside sources to identify potential risks to patients and opportunities for improvement.

REFERENCED ORGANIZATIONS

AAAHC- Accreditation Association for Ambulatory Health Care, Inc., <http://www.aaahc.org/>
AHRQ – Agency for Healthcare Research and Quality, <https://www.ahrq.gov/>
CDC- Centers for Disease Control and Prevention, <https://www.cdc.gov/>
CMS-Centers for Medicare and Medicaid Services, <https://www.cms.gov/>
FDA- Food & Drug Administration, <https://www.fda.gov/>
NQF- National Quality Forum, <http://www.qualityforum.org/Home.aspx>
NPSF-National Patient Safety Foundation, <http://www.npsf.org/>
SMDA-Safe Medical Device Act, <https://www.fda.gov/MedicalDevices/Safety/ReportaProblem/default.htm>
VA Patient Safety PROGRAM, VA National Center for Patient Safety, <https://www.patientsafety.va.gov/>
WHO- World Health Organization, WHO.Int

ONGOING QUALITY AND RISK MANAGEMENT PERFORMANCE MEASUREMENTS (as applicable)

Customer Satisfaction Surveys

- Patient surveys done after discharge (Press Ganey)
- Post op phone calls
- Employee Surveys as designated by HCA
- Physician surveys as designated by HCA
- Patient grievances (response and corrective action)
- Physician complaints (response and corrective action)

Patient Flow

- On time start and flow of surgical cases
- Consistent delays in surgeries
- Turn around time
- Equipment issues
- Cancelled cases (pre and intra-op)

Anesthesia Care

- Conscious sedation monitoring standards are standardized and consistent
- Anesthesia Care: complications for general/regional, assessment and plan of care developed prior to the start of anesthesia, physiological monitoring

Pre-op Care

- Completion of One Medical Passport prior to day of procedure
- Use of anesthesia alerts to evaluate patient medical history to determine if patient a candidate for ambulatory surgery setting.
- Appropriate follow through on obtaining pre-op diagnostic studies per anesthesia guidelines and follow up on abnormal reports
- Pre op instructions
- DVT assessment –including use of SCD when indicated
- Falls Assessment
- Sleep Apnea assessment and Incentive Spirometer started on designated patient population (if applicable)

Intra-op Care and Processes

- Time Out/correct site process
- Retained foreign bodies
- Wrong sites
- Near misses
- Blood utilization

Complications

- Unexpected complications (during any phase of care)
- Post op DVT/PE
- Transfers to acute care (Direct Admits)
- Hospitalization or ED visit within 72 hours of discharge (Indirect Admits)
- Variances of expected performance through clinical record review
- Mortality within 7 days of procedure or related to procedure.
- Falls
- Burns
- Loss of Vision
- Unplanned vitrectomy following cataract surgery.(if applicable)
- TASS (if applicable)
- Monitor post op progress of total joints weekly until discharged by surgeon

Resuscitation

- Code blue drill(s)- Adult and Pediatric (if there is a pediatric population)
- Crash carts, Malignant Hyperthermia carts maintained according to policy
- Annual malignant hyperthermia drill
- Periodic lipid rescue drills (If applicable).

Diagnostics Results

- Pre-op diagnostic studies clinically reviewed and documented.
- Pre- and post operative diagnosis agreement

Medication Usage

- Utilize “One Source” truth for allergy documentation
- Medication Reconciliation process
- Medication errors

- Adverse drug reactions
- Appropriate labeling of high alert and look alike/sound alike medications
- Independent double checks of designated high risk medications
- Controlled substance audits with follow up on deficiencies noted
- Surveillance of security of medications and needles

Infection Control

- Annual infection control risk assessment
- Proactive influenza vaccination program
- Compliance with hand washing standards- direct observation.
- Compliance with cleaning protocols
- Compliance with appropriate pre-op hair removal
- Appropriate timing of pre-op prophylactic antibiotic administration
- Monitoring Normothermia for patients undergoing surgery > one hour
- Post-op infections (rate, type of organism, environmental causes) within 30 days of surgery
- Implant monitoring for 90 days
- OSHA training during orientation and annually
- Employee, physician, allied health and patient exposures
- Appropriate sterilization processes for instrumentation
- Appropriate endoscopy re-processing if applicable
- Monitoring of temperature and humidity of designated rooms
- Monitoring IUSS rates

Provision of Care/ Medical Record Review

- Appropriate credentialing and privileging of medical staff
- Physician H&P on chart prior to start of surgery
- H/P reviewed on day of surgery and updated if indicated
- Required elements of assessment documented
- Pain assessment on admission, during Phase I and prior to discharge
- Fall assessment during admission process and discharge
- Operative reports: timeliness, content, intra-operative progress note completion
- Appropriate monitoring during IV conscious sedation by non- anesthesia personnel.(if applicable)
- Timely medical record completion.
- Medication Reconciliation completed

Equipment

- Routine preventive maintenance
- Compliance with process of notification and removal of malfunctioning equipment.
- Initial and annual competencies
- Utilize "One Source" to verify appropriate use of equipment.

Safety

- Surveillance rounds and corrective follow up on deficiencies
- Process for notifying and following through on recalls
- Periodic checks for life safety and environmental equipment
- Fire drills
- Infant/child abduction drill
- Incapacitated/impaired healthcare provider drills
- Sharps prevention program

Emergency Preparedness

- Develop a Hazardous Vulnerability Analysis(HVAC) grid

- Written emergency preparedness plan that incorporates community resources
- Emergency preparedness drills and critique
- Active Shooter drill

Radiation Safety

- Initial physician delineation of privilege, proof of training on equipment and safety training. Staff education on equipment training and safety during orientation and annually.
- Compliance with radiation safety measures
- Appropriate use of radiology equipment and shielding
- Dosimeter badge reports

Patient Safety

- Use of two patient identifiers- direct observation
- One source truth for allergies noted and communicated
- Time out verification for procedures
- Surgical Site marking
- Appropriate use of abbreviations
- Latex allergy precautions
- Falls prevention guidelines
- DVT assessment
- Close calls (good catches)
- Hand off communication

Revised 12/26/2018

QI/RISK GOALS for 2019

CSG/HCA Initiatives

Compliance with CSG initiatives

- Endoscopy Toolkit
- Conscious Sedation Guidance
- Medication Safety-Diversion Guidebook

Clinical Safety Improvement Program 2019 Goals

1. AHRQ Culture of Patient Safety Survey results- Action Items and Implementation
2. Medical Director Engagement
3. Medication Safety-Guidebook Adoption, MDT meetings
4. SEA & Safe Table call participation

Add Market Goals if applicable

Add your Center specific goals

**~~PRESENT TO MEC/BOARD DURING FIRST 2019 MEETING
INCLUDE THE 2018 SUMMARY~~**

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Please revise and expand this template to meet your facility's needs.

Facility Name: Kindred Hospital Las Vegas
Sahara Flamingo Campus

QUALITY AND PATIENT SAFETY PLAN Template

DATE:

1/31/2017/1926/18901/01



This plan was created and revised by the ~~Kindred Hospital Las Vegas Sahara Flamingo Campus~~ (facility name) Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

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Patient Safety Committee/Program
Kindred Hospital Las Vegas Sahara Flamingo Campus Facility name:
2250 East Flamingo Road 5110 West Sahara Avenue
Las Vegas, Nevada 89119146

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Facility Address

Facility contact information

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Contents

Commitment to Patient Safety	<u>332</u>
Mission, Vision, and Values	<u>333</u>
Scope and Purpose	<u>433</u>
Roles and Responsibilities	<u>444</u>
Roles and Responsibilities	<u>65</u>
Objectives and Goals of the Quality and Patient Safety Plan	<u>988</u>
Components and Methods	<u>1288</u>
Root Cause Analysis	<u>1399</u>
Model for Improvement	<u>1410/10</u>
Data Collection and Reporting	<u>1511/11</u>
Assessment of the Quality and Patient Safety Plan	<u>1712/12</u>
Patient Safety Checklists and Patient Safety Policies	<u>1713/13</u>
Approval of Patient Safety Plan	<u>1915/15</u>
Reference	<u>2015/15</u>
Appendix A: Terms and Definitions	<u>2116/16</u>
Appendix B: Patient Safety Goals	<u>2318/18</u>
Appendix C: Fishbone Diagram	<u>2419/19</u>

Appendix D-1: PDSA Worksheet 252020
Appendix D-2: PDSA Monthly / Quarterly Progress Report 272222
Appendix E: Checklist Example: Injuries from Falls and Immobility 282323
Appendix F: Policy Example 292424

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Commitment to Patient Safety

Kindred Hospital Las Vegas Sahara Flamingo Campus (Facility name) is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

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Mission, Vision, and Values

In support of our mission, vision, and values, Kindred Hospital Las Vegas Sahara Flamingo Campus Patient Safety and Quality Improvement program promotes:

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

- Education of staff and physicians to assure participation of healthcare providers.

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Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in (facility name Kindred Hospital Las Vegas Sahara Flamingo Campus) are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

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This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, (facility name Kindred Hospital Las Vegas Sahara Flamingo Campus) has developed this Patient Safety Plan.

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

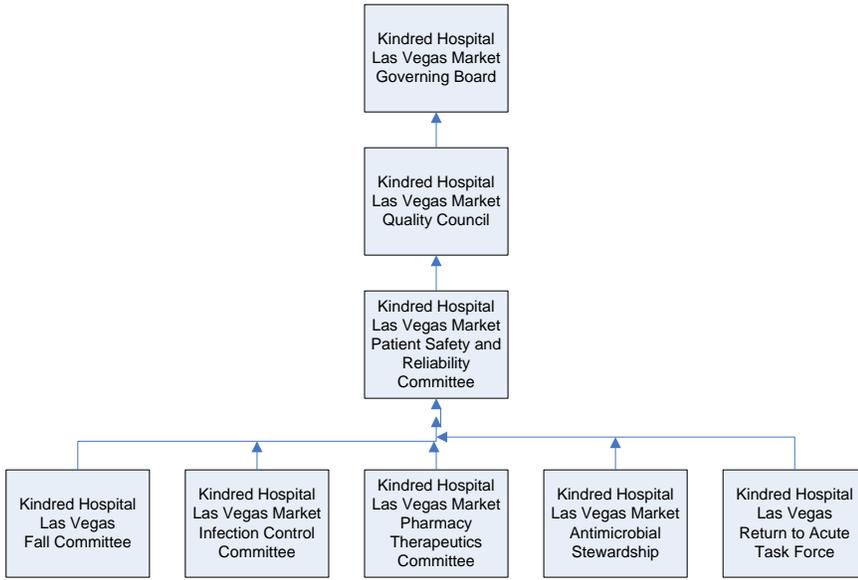
- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.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

Roles and Responsibilities

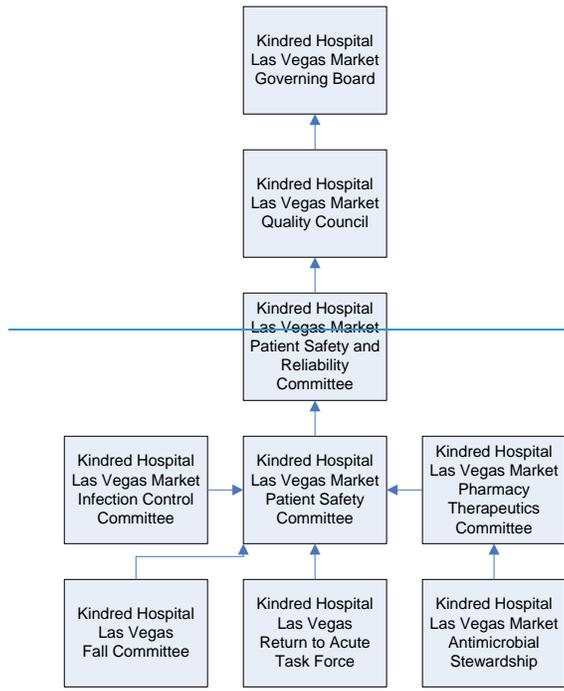
According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization

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Roles and Responsibilities

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

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

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

The roles and responsibilities are defined below (Please modify them as needed.)

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

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

Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

(Additional responsibilities here if needed)

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Infection Control Officer Responsibilities (based on [NRS 439.873](#))

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

~~—(Additional responsibilities here if needed)~~

RCA Team Leader Responsibilities ~~(please revise as needed)~~

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Provide vision and leadership to the Root Cause Analysis process
- Work with the Director of Quality Management to assure process changes are implemented
- Guide the staff in the process of discovery and mitigation of future process failures

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~~(Please provide the responsibilities here)~~

Executive or Governing Body Staff Responsibilities ~~(please revise as needed)~~

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

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~~(Please provide additional responsibilities here if needed)~~

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

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
	Reduce	1) Use Tegaderm	12/31/18	ICP/CCO

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<p><u>CLABSI Prevention</u> <u>CLABSI reduction and prevention</u></p>	<p><u>CLABSI by 10% Reduce by 10%</u></p>	<p><u>Dressings</u> 2) <u>CHG Bathing Program</u> 3) <u>Staff education and competencies on hire and annually thereafter</u> 4) <u>Develop nurse-driven protocol for discontinuation of lines</u> 5) <u>RCA performed for each event</u> 1. Use tegaderm dressings; 2. update education for new dressing kit; 3. conduct competencies; 4. CHG Bathing Program</p>	<p><u>str 2017</u></p>	<p><u>ICP/CCO</u></p>
<p><u>CAUTI Prevention</u> <u>CAUTI Reduction and Prevention</u></p>	<p><u>Reduce CAUTI by 10% Reduce by 10%</u></p>	<p>1) <u>Staff education and competencies on hire and annually thereafter</u> 2) <u>Evaluate use of external female urine systems</u> 3) <u>RCA performed for each event</u> Skills lab for pericare, foley care, cap secure with return demonstration</p>	<p><u>12/31/18</u> <u>12/31/16 and ongoing</u></p>	<p><u>ICP/CCO</u> <u>ICP/CCO</u></p>
<p><u>NOWPU Prevention</u> <u>HAP prevention</u></p>	<p><u>Reduce NOWPU by 10% Reduce by 10%</u></p>	<p>1) <u>Use of Patient Safety Index to assure HAPU prevention</u> 2) <u>Braden Scale, Repositioning, Assessment and Wound</u></p>	<p><u>12/31/18</u> <u>quarterly assessment</u></p>	<p><u>Wound Care Coordinator/ Chief Clinical Officer</u> <u>WCC/CCO</u></p>

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		<p>Education to Patient Family Score</p> <p>3) RCA done for each event Use of patient safety index to assure HAPU prevention: 4 items, braden scale, repositioning, wound assessment, and wound education to pt/family</p>		
<p><u>Antimicrobial Stewardship</u></p> <p><u>Employee health-</u></p>	<p>Reduce Antibiotic usage to < 35% of total drug cost; increase rate by 5%</p>	<p>1) Enhance the Patient Safety Dashboard for Antimicrobial Therapy Use</p> <p>2) Incorporate the Pharmacist/ICP/ Infectious Disease MD rounding</p> <p>3) Staff, physician and Leadership Education Vaccine education; use of isolation masks by staff unvaccinated personnel in clinical areas;</p>	<p>12/31/18 * apr 2016 may 2017</p>	<p>Director Pharmacy/ICP/ CCO/ID Medical Director EH/CC</p>
<p><u>Fall Reduction</u></p> <p><u>Antimicrobial stewardship</u></p>	<p>Reduce falls by 10% Reduce unnecessary antibiotic therapies</p>	<p>1) Fall risk assessment completed for each patient, each shift</p> <p>2) Reimplement market Fall Reduction Performance Improvement Team</p>	<p>12/31/18 7/1/16 completed</p>	<p>DQM/CCO POP</p>

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		<u>3) Staff education on hire and annually thereafter</u> <u>4) Post-fall assessment completed for each event</u> <u>Enhance the patient safety dashboard for antimicrobial therapy use; incorporate the pharmacist/ICP/Infectious MD rounding; education to staff and physicians</u>		

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Components and Methods

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

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

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Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in (facility name Kindred Hospital Las Vegas SaharaFlamingo, Campus) to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

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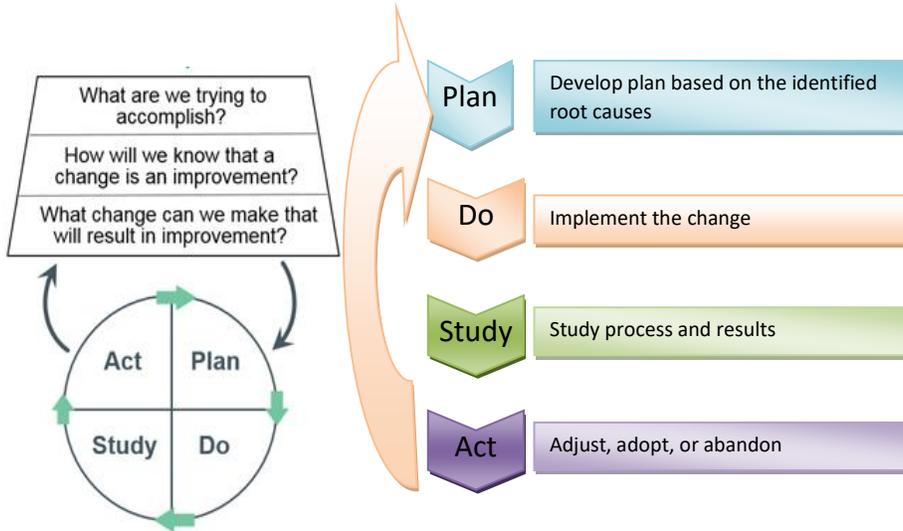
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why's technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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



The cycle is defined as follows:

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- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

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Data should drive any quality and patient safety effort. Kindred Hospital Las Vegas Sahara Campus is using the Kindred Event Reporting System for tracking the incident and sentinel events, NHSN for reporting healthcare infection data, WebIZ for reporting vaccinations, and Business Warehouse and Meditech for internal data collection.

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Data Collection and Reporting

Data should drive any quality and patient safety effort. (Facility name Kindred Hospital Las Vegas Sahara Flamingo Campus) is using Protouch (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) Infection Prevention IPAC Administrator, and the Kindred Hospital Di for internal data collection.

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External data sources are those data sources which are collected outside the supervisory

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structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

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



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
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1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising
--	--	--

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

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

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

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

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E**.)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

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Approval of Patient Safety Plan

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: (NRS 439.802)

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility (NRS 439.805)

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

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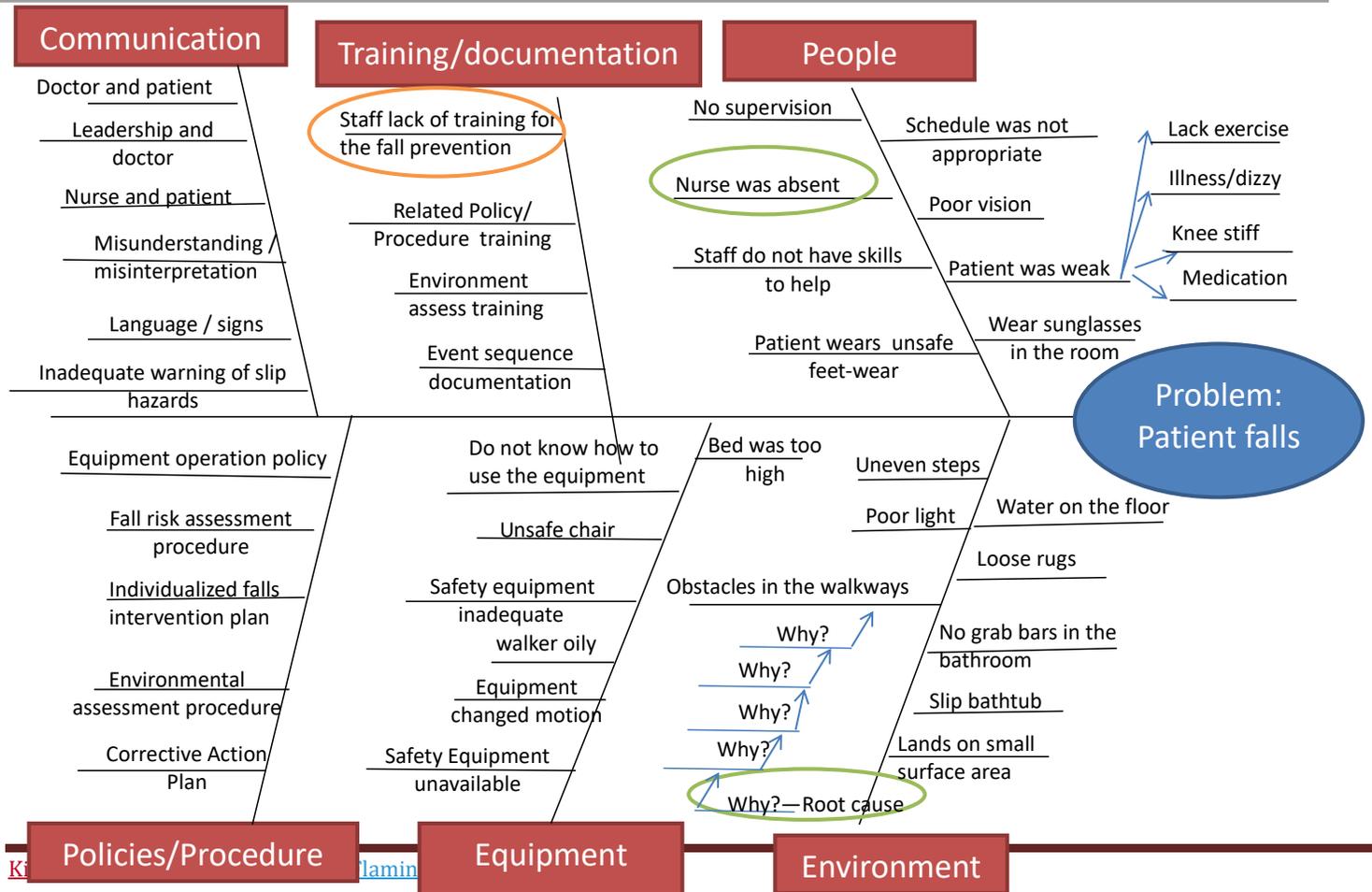
Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools.
	b. Establish an automated surveillance process.			Develop automated surveillance reports in Cerner.
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS.	
	b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.		Increase number of events reported by 10%.	
	c. Establish a process for providing feedback regarding reported events.		Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.	
	b. Establish a recognition program that rewards safe practices.		Include patient safety presentation in monthly New Employee Orientation.	
	c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
	b. Facilitate the development of action plans associated with measures not meeting benchmarks.	Complete 2014 Leapfrog Safety Survey.	Establish & implement a plan to improve performance of each leap.	
	c. Assess and improve processes related to hand-off, transition and communication	Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.		Establish Patient Safety Council.	
	b. Reduce and eliminate variation in care.		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram

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Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

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3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome
Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			

<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

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Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			

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Notes:	

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				

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Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
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	HOSPITAL POLICY AND INFORMATION MANUAL		
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee	

Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				
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Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQUIP5 - 1.5.1 and 1.5.2 Infection Control
- EQUIP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

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- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

Chapter 11 Safety

Safety

POLICY:

It is the policy of this Center in accordance with federal law, that all activities be conducted in the safest manner possible to protect our patients, our employees, the public, and to preserve our facility.

Safety is always to take precedence over expediency or shortcuts, and every attempt must be made by all employees to remove, correct, and/or report conditions that could cause accidents.

Exercise caution at all times in carrying out your duties. As you go about your work, you may observe unsafe conditions in the Center. If you cannot correct them yourself, report what you have seen to your supervisor and see that a warning sign, if necessary is posted.

You must also be on the lookout for fire hazards, which must be reported. In addition, be sure that your supervisor has explained your specific responsibilities in case of a fire, fire drill, or any other emergency condition.

It is the intent of all employees of this Center to provide services which directly and indirectly provide care needed by the patient and their significant others for whom we are responsible while within the Center until discharged or transferred from the premises.

We, therefore, urge employees to work cooperatively to achieve a functioning safety and health program to guard against injury and illness to themselves and to protect our patients from injury or the augmentation of existing illness.

OBJECTIVE:

To provide the safest facility possible to the patients, employees, and the public.

PROCEDURE: General Safety

Central Supply

1. Proper ventilation and adequate lighting must be maintained at all times.
2. Any accident or injury, no matter how slight, must be reported immediately and an incident report is to be filled out by the employee involved and signed and witnessed by the Director of Nursing or current nurse in charge.
3. Always use the proper step ladder for reaching high places. Do not use chairs, boxes, makeshifts on which to stand. Use hand rails.
4. All personnel are to be instructed in the proper methods of lifting and carrying. Improper lifting, reaching, climbing, or carrying are discouraged due to potential injuries.
5. Floors are to be kept clear and dry. Wipe up spills immediately.
6. Traffic areas must be kept clear of equipment and supplies.
7. Fire fighting equipment must be kept unobstructed.
8. Extreme caution must be exercised in the handling of all instruments. Pick up all instruments by their finger grips.
9. Report any unsafe condition that is observed.
10. Pick up or wipe any foreign matter found on the floor.

Chapter 11 Safety

Soiled Utility

1. All washer materials must be discarded according to established procedure.
2. Gloves must be used for all cleaning. When hand washing any items with a scrub brush, keep the item and the brush below the surface of the cleaning solution in the sink. This will prevent the spraying and spreading of organisms that are on the item into the air and onto yourself.
3. Do not wear jewelry.
4. Never lift anything that cannot be lifted comfortably and safely. Ask for help whenever necessary.
5. Do not pick up broken glass with your hands. Follow the procedure listed below:
 - A. Sweep up glass that has broken on the floor.
 - B. Use small forceps or tweezers to get glass out of the sink drain.
 - C. Wipe glass off counter top with damp cloth, towel, or cotton.
 - D. Broken glass – all glass can be discarded in the sharps container for needles, razors, and scalpels.
 - 1) Needles: Discard into sharps container in decontamination area.
 - 2) Scalpels: NEVER discard into waste basket. Sharps container also available in clean preparation area.
 - 3) Razors: Discard into sharps container in decontamination area.
 - E. Broken glass adapters in rubber tubing is a danger to the processing employee, the patients, and the equipment. We cannot be positive that all the glass splinters have been removed from the inside of the tubing. Tubing in this condition should be disposed of.
 - F. Handle all instrument trays carefully. Remove towels carefully, inspect thoroughly, watch for falling needles, knife blades, and broken glass.
6. Wear autoclave glove to open door of washer/sterilizer. Allow residual steam in chamber to escape.
7. Be extremely careful and alert to water on the floor – wipe up any water spots.

Clean Utility

1. DANGER HOT Remember that sterilizers and cart wash are very hot. Sterilizer jacket temperature reaches 270-275 F.
2. When opening door of autoclave, employee should step back away from the door to avoid being burned by escaping steam. Always cover hands when removing carts that have been steam sterilized.
3. Never lift more than one full instrument tray at a time.
4. Watch for SHARP or SEMI-SHARP instruments (scissors, shears, chisels, towel clips) while sorting them. Always grasp instruments by the finger grip end.
5. Employees should never push against walls when stocking them.
6. Carts are not to be overloaded. If you cannot easily propel a cart over carpeting, it is overloaded. Load carts so that you can see over, thru, or around the cart. If a cart should begin to tip over, DO NOT try to hold it – let it go. Supplies can be replaced – your back cannot.
7. NEEDLES, SCALPELS, RAZORS – discard into containers in the soiled utility. NEVER discard into wastebasket. Container also available in clean utility area.
8. GLASS – All glass can be discarded into any plastic lined wastebasket. Broken glass must be discarded in the sharps container for needles, razors, and scalpels.

Equipment Safety

1. All equipment used must be checked for electrical and mechanical safety prior to use.
2. Defective equipment must be removed from the area and repaired and recertified prior to use.
3. All equipment must be maintained in accordance with manufacture's recommendations and preventive maintenance schedules.
4. All electrical equipment that comes into patient contact will be inspected on a bi-annual basis.
5. Documentation of inspections and preventive maintenance must contain the date of inspections and/or service, the type of service performed, and the signature of person performing the inspection or service.

Chapter 11 Safety

6. All personnel must be trained in the handling, care, and use of center equipment and supplies.
7. Manufacturer's safety and inspection booklet must be on file and available in the center.
8. All personnel must be warned of any potential hazards in the use or handling of equipment. This includes electrical, mechanical, chemical, gas, or any other known hazard.
9. All drawers should be kept clean. Do not mix sharp instruments or needles with other instruments. Keep each type of instrument in separate places.
10. Never use contents of an unlabeled bottle. Unlabeled containers shall be discarded.

Electrical Equipment (Safety and Use)

1. DO NOT connect or disconnect any electrical operated equipment to an electrical outlet with wet or moist hands. Inspect all cords and plugs before inserting into electrical outlet.
2. All electrical equipment shall be equipped with an approved 3-prong ground plug.
3. All power cords shall be kept clear of the plumbing fixtures, water pipes, radiators, and other equipment in contact with the ground.
4. Plug adapters or cheater plugs shall never be used.
5. Any electrical wire with cut, broken, or frayed insulation shall be removed from service immediately. Tag equipment "Do Not Use – in Need of Repair"

Chapter 11
Safety

Spring Valley Hospital

**Risk Management/
Patient Safety Plan**

Nevada Acute Care Division

Revised 1/2019

I. Overview

Spring Valley Hospital endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. **Spring Valley Hospital** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **Spring Valley Hospital** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **Spring Valley Hospital** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **Spring Valley Hospital**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **Spring Valley Hospital** policies. **Spring Valley Hospital** employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.

- Evaluation and documentation of the effectiveness of actions implemented.
- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

Spring Valley Hospital mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

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

Spring Valley Hospital recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

Spring Valley Hospital has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

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

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

Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

Spring Valley Hospital has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **Spring Valley Hospital** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

Spring Valley Hospital PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.

- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Spring Valley Hospital is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. Risk Connect (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the

facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

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

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. UHSD Acute Care Division Patient Safety Priorities, Goals and Objectives for 2019

- **Surgical and Procedural Safety:**
 - **Wrong Site Surgery.**

- 5% reduction of 2019 Violence related harm events. Increase utilization of security assists with subsequent decrease in security emergency utilization which will further impact harm events.
 - Monitor through Midas EOC Dashboard, Loss Control Reports, Serious Incident debriefing and HealthStream training modules. Report quarterly with oversight by CPSC.
- **CLABSI/CAUTI Initiative**
 - **Goal:** CLABSI and CAUTI rates will be reduced by 10% each in 2019.
 - Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly with oversight by CPSC.
- **Executive Engagement in Safety/Safety Huddles**
 - **Goal:** 100% of essential safety huddle elements will be included in all hospital unit/department and Executive Safety Huddles.
 - Monitor through Observation/Mentoring Forms completed by Patient Safety Leads and Corporate resources. Report monthly with oversight by CPSC.
- **Safe Medication Use**
 - **Emergency Department Pyxis Optimization**
 - **Goal:**
 - Identify those limited emergency departments with ADCs that are not in profile mode.
 - Assess the barriers to converting those ADCs to profile mode and create a timeline for conversion by mid-Q1 2019.
 - Convert 100% of ADCs in the emergency departments to profile by Q2 2019.
 - Decrease the number of all-harm, medication events related to ADC overrides by 10% by December 2019.
 - Monitor through MIDAS reports, trigger tools, Cerner orders, and other intervention data. Report monthly with oversight by CPSC.
 - **Opioid Analgesic Event Reduction Initiative**
 - **Goal:** decrease the number of adverse drug events related to opioids by 10% by the end of 2019.
 - Monitor through Cerner, MIDAS, ICD-10 codes, and intervention data. Report monthly with oversight by CPSC.
 - **High Alert Medication Error Reduction**
 - **Goal:** 10% error reduction goal with warfarin and insulin medication administration errors.

- Monitor through MIDAS, Cerner, PSO reports, Pharmacist Interventions. Report monthly with oversight by CPSC.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls in the acute division by end of 2019.
 - Monitor through MIDAS event reporting. Report quarterly with oversight by CPSC.
- **Increase Incident Reporting**
 - **Goal:** 10% increase in incident reporting from 2018's average rate, to be met by the end of 2019.
 - Monitor through MIDAS event reporting with monthly reporting to PSC.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of "Near Miss" events

- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

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

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

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

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety

is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Spring Valley Surgery Center LLC

2018 Sentinel event reporting

3835 S. Jones Blvd. Las Vegas NV 89103 License #: 3421

2705 W. Horizon Ridge Pkwy Henderson NV 89052 License #: 5491

7175 N. Durango Drive Las Vegas NV 89149 License #: 7592

1900 N. Nellis Blvd Las Vegas NV 89115 License #: 7891

1050 E. Sahara Ave Las Vegas NV 89104 License #: 8688

8828 Mohawk Street Las Vegas NV 89139 License #: 8787

Safety committee:

The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the Federal, State, Local and OSHA guidelines. The “Safety Plan” includes identification, evaluation and prevention of workplace hazards relating to the elements and specific criteria. The safety management of the Facility is composed of several elements regarding the safety features necessary for the protection and security of its patients and healthcare workers.

These elements are composed of two parts; one “Life Safety Enterprise Safety Plan” which is wide in scope, organizational and effectiveness, and the “Environmental Safety Management” which oversees the working environment elements of the Facility. These areas overlap each other but also provide individual elements which manage the overall security and safety of the Facility. A report from the Safety Committee is provided quarterly to the Medical Executive Committee (MEC) and onto the Governing Board. The Safety Committee meets and discusses how to improve and/or maintain patient and employee well-being and safety, items discussed range from falls to how to properly lift boxes, and the execution of a disaster drills, etcetera. If any incidents have occurred they will be discussed in detail, and prevention and safety will be implemented.

PATIENT SAFETY PLAN

1. Aseptic technique to be used during surgical intervention per facility policy
 - Multi-dose vial policy for the facility
 - Sterile technique for injections
 - Single dose vial policy for the facility

2. Infection Control per facility policy
 - Post surgical infection survey policy
 - Care of infectious patients

3. Pharmacist monthly reviews

4. Monthly safety inspections to assure a safe environment.

Please revise and expand this template to meet your facility's needs.

Facility Name: Seven Hills Surgery Center

QUALITY AND PATIENT SAFETY PLAN Template

DATE: 02/19/2019
VERSION: XX



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

Patient Safety Committee/Program

Facility name: Seven Hills Surgery Center

876 Seven Hills Dr
Henderson, NV 89052
(702)914-2028

Table of Contents

Commitment to Patient Safety.....	3
Mission, Vision, and Values	3
Scope and Purpose.....	3
Roles and Responsibilities.....	4
Roles and Responsibilities	5
Objectives and Goals of the Quality and Patient Safety Plan	8
Components and Methods	8
Root Cause Analysis.....	9
Model for Improvement.....	10
Data Collection and Reporting.....	11
Assessment of the Quality and Patient Safety Plan	12
Patient Safety Checklists and Patient Safety Policies	13
Approval of Patient Safety Plan.....	15
Reference.....	15
Appendix A: Terms and Definitions	16
Appendix B: Patient Safety Goals	18
Appendix D-1: PDSA Worksheet.....	18
Appendix D-2: PDSA Monthly / Quarterly Progress Report	19
Appendix E: Checklist Example: Injuries from Falls and Immobility.....	21
Appendix F: Policy Example.....	22

Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, (Seven Hills Surgery Center) Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in (Seven Hills Surgery Center) are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

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

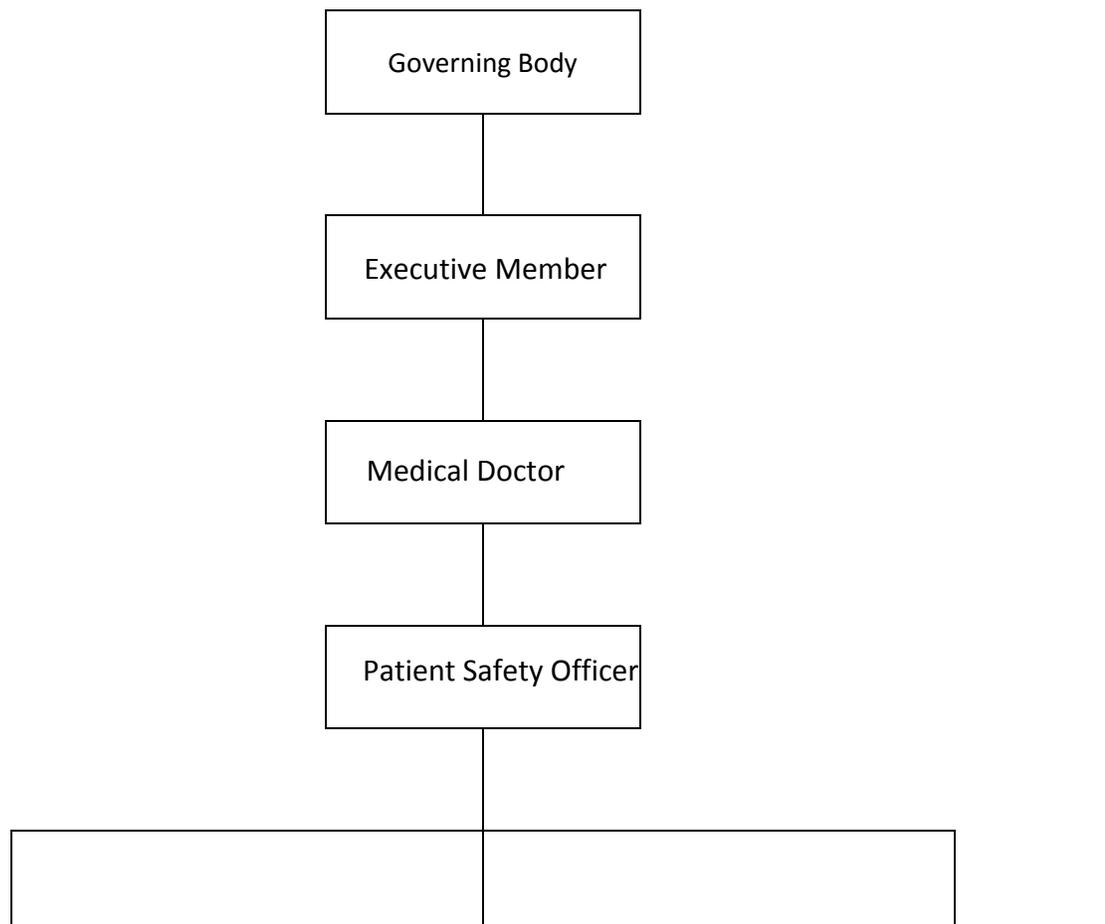
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

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

Roles and Responsibilities

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

The Patient Safety Committee Organization



Pharmacist

Infection Control Officer

Administrator

Roles and Responsibilities

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

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

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

The roles and responsibilities are defined below (Please modify them as needed.)

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

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

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

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

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

Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

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

RCA team leader Responsibilities (please revise as needed)

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.

- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities (please revise as needed)

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

The Patient Safety Committee will meet monthly to accomplish the following:

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

Pursuant to [NRS 439.837](#) and [NAC 439.917](#), within 45 days after reporting a sentinel event pursuant to [NRS 439.835](#), the medical facility shall conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

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



Root Cause Analysis

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

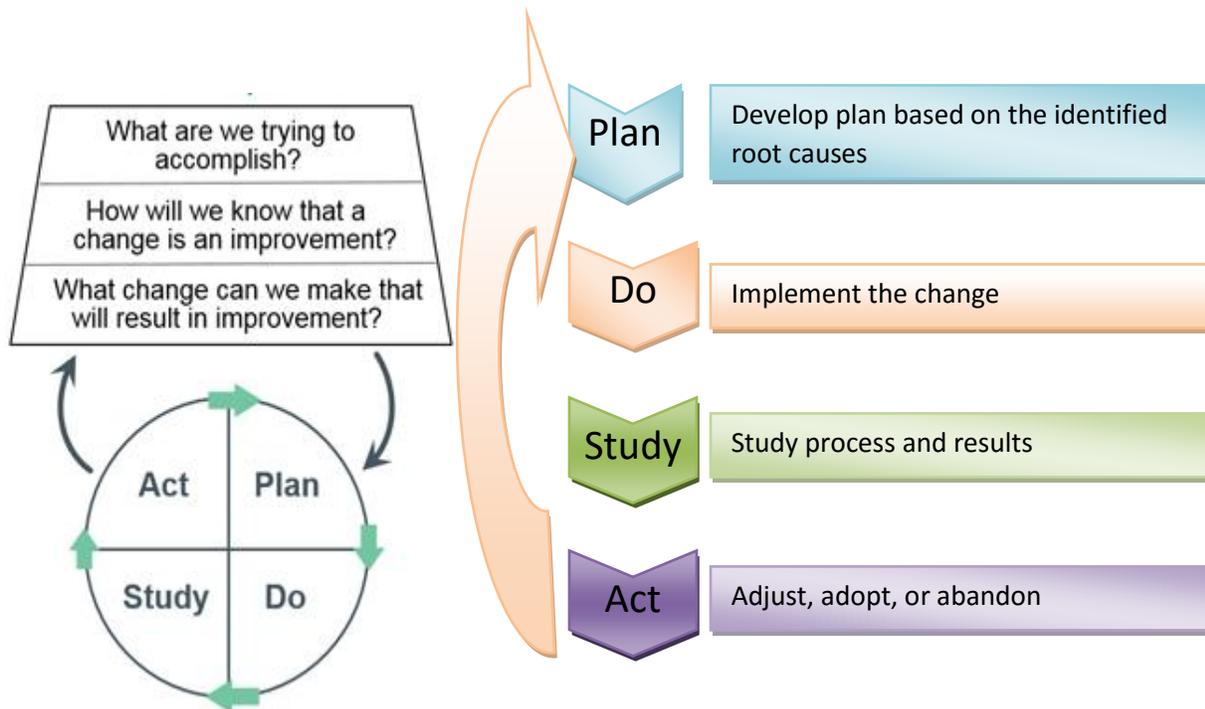
Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases.

5 Whys technique will be used in (Seven Hills Surgery Center) to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times.

Model for Improvement

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



The cycle is defined as follows:

- Plan--Collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--Make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
 - Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
 - Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. (Seven Hills Surgery Center) is using (internal processes) for tracking the sentinel events, healthcare infection data, and (Amkai) for internal data collection.

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

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



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

The patient safety checklists are listed in Appendix E. The following links provide some patient safety checklists for your reference-a checklist example is shown in Appendix E.

<http://www.hpoe.org/Reports-HPOE/Cklist PatientSafety.pdf>
<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference- a policy example is shown in Appendix F).

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: (NRS 439.802)

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility (NRS 439.805)

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRRENT_b.pdf.)

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS. Increase number of events reported by 10%. Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans.	Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee. Establish & implement a plan to improve performance of each leap.	
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.		Establish Patient Safety Council. Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Patient Safety and Quality Improvement Plan

Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	
<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: 07/01 08/14 Date Last Revised: 08/17 Next Review Date: Approved By: Policy Committee</p>	

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

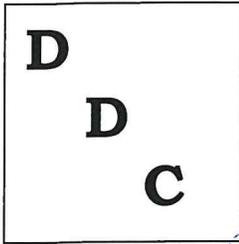
- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports



**P A T I E N T S A F E T Y
P O L I C Y & P R O C E D U R E**

Policy:

The policy set forth by the Digestive Disease Center (DDC) is to ensure patient safety, before, during, and after a patient's procedure.

Procedure:

- A. Each patient will have a history & physical examination documented in their chart within 7 days prior to their procedure.
- B. Each patient will complete the Medical History Questionnaire prior to his or her procedure.
- C. All patients will receive a copy of the Patient Rights and Responsibilities at the time of scheduling of procedure.
- D. All medical staff is CPR certified, and aware of the location and use of all emergency equipment. All DDC Physicians are ACLS certified.
- E. At least one ACLS certified Registered Nurse is staffed when patients are present in the facility, along with ACLS trained Anesthesiologist is present with sedated patients.
- F. Once a patient has been admitted to the facility, non-sedated patients are visualized frequently to ensure needs are met. Sedated patients are monitored closely checking vital signs with observation to assure patients are free from complications related to the procedure and /or medical problems
- G. Each patient will meet the required discharge criteria set forth by DDC, and ANOR anesthesia standard, prior to being discharged. The physician will have the final decision, to discharge the patient, which will be documented, signed and become part of the patient's record.
- H. A written physician discharge order will be issued to each patient post procedure, providing them with post procedure instructions, precautions, and contact information in case of an emergency. A copy of this document will become part of the patient's record.
- I. The facility staff will make a follow up appointment for the patient as ordered by the physician.
- J. Each patient will be contacted within 24 hours after having their procedure to ensure that they are not experiencing any complications related to the procedure.
- K. A patient safety committee will be formed to include one physician from each site, the nurse manager from each site, the pharmacy consultant, and the medical director. The committee will meet quarterly to discuss patient safety.

Centennial Surgery Center

Patient Safety Plan 2019

Prepared by: Name Here, RN

Reviewed by: CSC Patient Safety Committee & Medical Executive Committee

I. Introduction:

The Patient Safety Program supports and promotes the mission, vision and values of Centennial Surgery Center through organizational prioritization of patient, visitor and employee safety.

II. Purpose:

The purpose of this plan is to institute a Patient Safe4ty Program for Centennial Surgery Center. The plan incorporates education, communication, consistency and effectiveness of safety practices. CSC implements and maintains patient safety program in accordance with Standards of Practice by AAAHC and guidelines from the State of Nevada and federal regulatory agencies.

III. Responsibility

It is the responsibility of all employees of Centennial Surgery Center to be familiar with the contents of this plan and adhere to the procedure outlined within.

IV. Mission, Vision and Values:

In support of the mission, vision and values of Centennial Surgery Center, the Patient Safety Program promotes:

- A focus on comprehensive, integrated quality patient care
- Collaboration among staff members, physicians and other providers to deliver comprehensive, integrated and quality health care
- Effective and open communication to foster trust relationships among staff, physicians, other providers and patients.

V. Objectives:

The objectives of the Patient Safety Program include:

- Organization in-service regarding potential adverse events
- Incorporate recognition of patient safety as an integral job responsibility
- Provide patient safety education
- Sharing of knowledge to effect change
- Collect and analyze data, evaluate care processes to reduce risk and initiate proactive measures

- Report internally the findings and actions taken to reduce risk

VI. Responsibilities/Duties

The Patient Safety Committee provides a multidisciplinary forum for the collection and analysis of risk to patient safety and the dissemination of information on identified risk, for the purpose of improving patient care. It reviews reports on occurrences including near misses to sentinel events. It identifies groups or individuals to perform root cause analysis and develop action plans for identified issues. It will report this information to the Executive Committee.

VII. Scope

The types of occurrences to be addressed include, but are not limited to, near misses and actual events related to:

- a) Patient safety
- b) Adverse drug events
- c) Nosocomial infections
- d) Patient falls
- e) Unsafe conditions
- f) Unexpected clinical events
- g) Visitor safety
- h) Employee safety
 - o Blood/body fluid exposure
 - o Communicable disease exposure
 - o Immunization programs
 - o Injuries
 - o Occupational diseases
- i) Environmental safety
 - o Disaster planning
 - o Security incidents
 - o Drug recalls
 - o Product recalls
 - o Product/equipment malfunction
 - o Infection control risk assessment

Data from external sources, including but not limited to:

- Center for Disease Control and Prevention (CDC)
- Association of Operating Room Nurses (AORN)
- Institute for Safe medication Practices (ISMP)
- Occupational Safety and Health Administration (OSHA)
- Association of Professional in Infection Control (APIC)
- American Association of Medical Instrumentation (AAMI)
- American Association of PeriAnesthesia Nurses

VIII. Definitions

Near Miss: An error that could have caused harm but did not reach the patient because it was intercepted.

Minor Error: An error that does not cause harm or have the potential to do so.

Serious Error: An error resulting in patient injury including the potential to cause permanent injury or transient but potentially life-threatening harm.

Medical Error is defined as failure of planned action to be completed as intended or the use of a wrong plan to achieve an aim. Medical Errors may or may not cause harm.

Adverse (Sentinel) Event is defined as an unexpected occurrence that involves death or serious physical or psychological injury, or the risk that these might occur.

IX. Structure

The authority for the Patient Safety plan rests with the Executive committee and has delegated the authority to implement and maintain activities in the plan to the Patient Safety Committee, chaired by the surgery center administrator.

X. Quality Review

In a manner consistent with the protection of confidentiality, quality assurance and patient safety data will be shared between Quality Improvement Program and Patient Safety Program.

XI. Education

- Fire education annually and Fire Drills quarterly
- Emergency and disaster drill
- Risk management and Error Prevention
- Intruder Drill
- Workplace Violence
- Creating, Implementing, Achieving, & Maintaining a Culture of Patient safety
- Team Work

XII. Safety Improvement Activities

Measures Selected for Annual Focus 2015:

- Patient Satisfaction Surveys
- Medication Management and Reconciliation
- Hand Washing Surveillance
- Informed Consent Doctrine
- Complaints and Resolution – trend and analyze
- Safety Surveillance – log monthly
- Involve patients in their health care
- Endorse open, effective communication, identify values and attitudes
- Examine physical premises to identify and correct potential hazardous conditions
- Provide education and training on high risk processes

- Orient physicians and new employees to risk management and patient safety concepts
- Use team approach to safety, hold focused safety meetings

XIII. Methodology

- Structure:
 - Identification of high risk areas
 - Potential or actual adverse event
 - Proactive risk prevention strategies
- Method
 - Identification and prioritization of safety concern
 - Data collection
 - Develop action plan
 - Implementation
 - Reporting of data
 - Follow up
- Process Improvement Tools Utilized
 - PDCA: (Plan, Do Check, Act) Focus on process improvement
 - FMEA: (Failure Mode Effect Analysis) Systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk.
 - RCA: (Root Cause Analysis) Retrospective approach to error analysis that identifies what and how event occurred and why it happened. The focus is on the processes and systems not individuals.

IX. Program Evaluation

The Patient Safety committee report quarterly to the Executive Committee. The report will include:

- Definition and scope of occurrences including sentinel events, near misses and serious occurrences.
- Detail of patient safety activities
- Proactive activities to promote patient safety
- Description of ongoing staff education and training programs that maintain competence and patient safety
- Reporting of QI studies targeting patient safety and satisfaction

Effective as of: 10-6-09
Reviewed & approved January 2019

Quality Improvement Plan

SUMMIT Surgery Center

Approved by the Medical Staff

By: _____ Dated: _____

Its President

Adopted by the Managing Body

By: _____ Dated: _____

Authorized Representative

SUMMIT Surgery Center

Quality Improvement Plan

Purpose:

This organization provides ongoing monitoring of important aspects of the care provided. Health care professionals participate in the development and application of the criteria used to evaluate the care they provide. The Quality Improvement (QI) program addresses clinical, administrative and cost-of-care issues, as well as actual patient outcomes. Data related to established criteria are collected in an ongoing manner. Collected data are periodically evaluated to identify unacceptable or unexpected trends or occurrences that influence patient outcomes. Information will be gathered, logged and identified on a quarterly basis by the Quality Improvement Committee. This will include the laboratory consultant who will review all logs kept (i.e. blood glucose). The radiology safety officer will monitor the radiation safety issues for the facility including radiation badge levels. The pharmacy consultant will review all pertinent pharmacy data including narcotic review monthly. In addition, the contract service providers may provide appropriate in-service education for the staff of the facility as requested by the facility.

QI Indicators to be monitored will include:

- 1) Patient Satisfaction, Employee Satisfaction, Physician Satisfaction
- 2) Patient Follow-up: a) post op phone calls b) post –op complications
- 3) Post Operative Occurrences
- 4) Medication Use , Pharmacist review, Adverse Reaction Log & Medication Error Log per occurrence reporting system
- 5) Cancellations on Day of Surgery
- 6) Medical Record Review
- 7) Safety
- 8) Infection Control
- 9) Credentials
- 10) Employee Files
- 11) Ancillary Services
- 12) Employee Blood Borne Pathogen Exposures
- 13.) Patient Complications – Transfers, Returns to Surgery,

Quality Improvement Issues:

In addition to the on-going monitoring of QI indicators, staff and department managers will be encouraged to develop and assess “Quality Improvement Issues” to ensure department concerns are addressed and corrected. QI activities are consistent with the characteristics of the organization’s overall QI program. QI activities will follow the five steps of “closing the QI loop”.

Routine monitoring will also include:

- Emergency Cart / Defibrillator checks
- Refrigerator and Fluid warmer temperature checks.

The Quality Improvement Plan, the Peer Review Plan and Processes and the Risk Management Plan are all integrally inter-related in the overall quality processes of the ASC. When one process is affected, all subsequent processes and plans can be affected and may require follow-up and/or evaluation of the quality of care provided and the risks to the facility.

Quality Improvement Annual Review:

The Quality Improvement Plan will be evaluated and/or updated by the organization on at least an annual basis. The evaluation will be completed by designated personnel, including, but not limited to the Administrator, the QI Nurse, etc. Results of the QI Plan annual review will be reported to the Governing Body.

Benchmarking:

The surgery center has a process in place to review key indicators in comparison to other similar organizations and surgery centers. The Benchmarking data collected is analyzed and reviewed to determine areas of patient care that may need to be addressed to reduce the gaps from benchmarking norms. Both internal and external benchmarks are evaluated and utilized in QI activities.

Risk Management:

The QI Plan includes a risk management plan, with policies and processes to maintain an environment designed to protect the life and welfare of our patients, visitors and employees.

Responsibility:

The Board of Directors has the ultimate responsibility to continually evaluate and if necessary, improve the quality of care. The Administrator has the responsibility to implement the Quality Improvement Plan. The Board of Directors and Medical Executive Committee (MEC) will review and approve the plan. The Quality Improvement Coordinator will be responsible to oversee the ongoing operations of the Quality Improvement Plan. The Quality Improvement Committee will meet at least quarterly to review the data and make recommendations to the MEC and the Board.

Committee Composition:

The professional and administrative staff of the Surgery Center understands, supports, and participates in programs of quality management and improvement, through organized mechanisms responsible to the governing body. Contracted services provided to the facility will participate in the quality improvement plan of the facility on an ad hoc basis. This will include radiology laboratory, environmental and pharmacy services. The committee will be comprised of key staff, management and a physician appointed by the Board:

Medical Director: Shelli Tiller

Administrator: Michelle Mays

QI Coordinator/D.O.N.: Nancy Dibble

OR Supervisor: Jodi Eldridge

PACU Supervisor: Shonda Williams

Ad HOC members:

Pharmacy Consultant: Mary Grear

Laboratory Consultant: Amy Zabrosky

Environmental Consultant: Engineer from Saint Mary's

Housekeeping Services: Xtra Clean

Medical Executive Committee: MEC chair Dr Shelli Tiller

Radiology Consultant: Radiologist from Saint Mary's

The managers may delegate to their staff in their respective department (i.e. pre-op/PACU, OR and Business Office) the responsibility to gather information to further the quality of care at the facility.

Scope of Care:

The facility provides services to all patients who require treatment and procedures on an ambulatory surgery basis.

Communication:

The QI committee will meet at least quarterly to review, monitor and evaluate all information gathered. All activities will be documented on the quarterly report. The committee will summarize all activity and submit a report to the MEC for review. The MEC will give direction and recommendation for the approved activity and then report results to the Governing Board. Finding of quality improvement activities are incorporated into the organization's educational activities. Information is communicated through the organization via feedback from the Administrator, QI Coordinator and/or managers to the staff members at the staff meetings so they can have the opportunity to participate in the plan.

Assessment will be a continued process to recognize priorities. Appropriate records of QI activities will be maintained.

Quality Improvement Goals and Objectives of the Quality Management / Quality Improvement Program focus on the following patient care services and priorities:

- Improving patient health outcomes through the identification and reduction of medical errors,
- Evaluating high risk, high volume, problem prone areas and the incidence, prevalence and severity in these areas
- Evaluating high risk, low volume, problem prone areas and the incidence, prevalence and the severity in these areas
- Trending and implementing strategies and processes that positively effect health outcomes for patients, staff and the medical staff,
- Evaluating, developing and implementing defined performance measures or indicators for patient safety and the quality of care provided including medical necessity and the appropriateness of care provided.

Performance Improvement Activities will consistently track all:

- Adverse patient events,
- Examine the causes,
- Implement improvements approved by leadership, and
- Re-check to ensure that improvements are sustained over time

Elements and Composition of the Quality Improvement Plan:

The Quality Improvement Plan is an integrated plan which addresses both administrative and clinical outcomes of the Surgery Center.

1. Identification of Problems and Concerns –
 - This is accomplished thru audits, complaints and occurrence reports, which are tracked and trended within the surgery center as well as after patient discharge.
2. Participation of physicians, allied health professionals, office staff personnel and administration –
 - A member from each department of the surgery center will participate in the Quality Improvement Committee. At least 2 physicians will be involved in evaluating all quality of care issues
3. Evaluation of frequency, severity, and the sources of suspected problems and concerns and evaluation of whether policies and procedures should be revised –
 - As all occurrences are tracked, trended and evaluated by both the QI committee and the governing body, recommendation regarding policy and procedure changes will be evaluated as well, and policy changes based on current standards of care.
4. Review of related processes and implementation of measures to address and resolve identified problems or concerns-
 - Recommendations and comparisons will be made by the QI committee to present to the Governing Body, addressing possible solution paths to implement in order to resolve identified problems or concerns within the facility.
5. Re-evaluation of problems or concerns to determine objectively whether the corrective measures achieved and sustained and the desired results –
 - All problems or concerns will be re-evaluated or re-studied to determine if corrective measures implemented or changed in policy and procedures have been effective or need to be changed in order to maintain desired change or results.
6. Reporting of findings to the governing body –
 - All findings of outcomes, problems or concerns will be reported to the Governing Body on a least quarterly basis. Additionally, all measures implemented or changed will have outcomes of such changes reported to the Governing Body in order to evaluate if changes or measures have been effective or ineffective and if further evaluation is needed in the long term or short term.

Quality Improvement Indicators

1. SATISFACTION SURVEYS

- a. Patient
- b. Employee
- c. Physician

Tool:

Patient/Family Satisfaction Questionnaire (CTQ)

CTQ has been contracted to send each patient a patient satisfaction survey via e-mail or mail. The facility is immediately notified of any negative surveys or of patients who request to be contacted. When returned, these surveys are inputted into an analysis report and provided to the Q.I. team who will review them accordingly and assimilate them into the Patient Evaluation Summary.

Evaluation Summary of each population

CTQ sends the facility a form summarizing the information received from the satisfaction surveys and reports. It enables the center to monitor the percentage of surveys returned and define follow-up actions that may be necessary in response to patient complaints, employee and physician concerns.

Percentage Monitored:

100% - all patients

Frequency:

Employee satisfaction survey is done once a year

Physician satisfaction survey is done a minimum of annually

Patient satisfaction survey is done on each patient and results are sent each month

Threshold:

Meet or exceed national benchmark of like facilities

Follow-Up:

Results of the indicator will be presented at the staff meetings, QI meetings and Board meetings. Cases of noncompliance with this indicator will be discussed at these meeting and also presented to the Q.I. Committee so improvements can be made.

Quarterly reports to Administration and D.O.N..

2. OPPORTUNITIES ENCOUNTERED ON PATIENT FOLLOW-UP

Tool:

Post-Operative Nursing Follow-up Call Form

All patients will be called by an R.N. within two working days after surgery and this form will be completed. If the patient is unable to be reached, a letter will be sent by the third working day. Anytime a patient is referred to their physician for a post-operative complication this completed form will be given to the D.O.N.

Post-op follow up (unable to reach card) will be mailed to each patient that was able to be reached for their follow up call.

Post-operative Complication Log

Per occurrence reports, a summary is filled out with the information received from the patient follow-up phone calls. It enables the center to monitor the complications and define actions that may be necessary to improve on patient care &/or post-op instructions.

Percentage Monitored:

Post-Op Nursing Follow-up Call attempt to contact 100% of patients within 24 hours, except for Friday patients as the amended Medicare regulation states. Those with post-op complications will be investigated through follow-up with patient and physician.

Frequency:

Reported Monthly

Threshold:

100% of the comments will be addressed to the staff for opportunity to improve or provide surveillance for change.

Follow-Up:

Results of the indicator will be presented at the monthly staff meeting. Cases of non-compliance with this indicator will be discussed at these meeting and also presented to the Q.I. Committee so that improvements can be made.

3. POST OPERATIVE OCCURRENCES

Tool:

A. Physician Review Form

This form will be completed by the assigned staff in procedures where there are complications prior to and/or during the surgery that may be related to anesthesia or surgical intervention patients who have an extended recovery period or are transferred to a hospital, are also reviewed.

B. Return to OR, Injury/Death to patient & Transfer Log

A log book will be maintained to monitor unanticipated returns, injury/deaths & transfers to a hospital. The person caring for the patient will enter the information on the occurrence report. The QI Committee will monitor and assimilate the information in the log book.

Percentage Monitored:

1. Physician Review Form – 100% of applicable cases.
2. Return, Injury/Death, & Transfer Log – 100%.

Frequency:

1. Physician Review Form – quarterly
2. Return, Injury/Death, & Transfer Log – quarterly

Threshold:

100% of post-op occurrences will be followed as appropriate.

Follow-up:

Results of the indicator will be presented at the quarterly MEC meeting. Cases of non-compliance with this indicator will be discussed at these meeting and also presented to the Q.I. Committee so improvements can be made. The Q.I. Committee will also be made aware of the number of unanticipated occurrences and respond accordingly.

4. MEDICATION USE

Tool:

- A. Pharmacy Review Documentation
This form will be complete by the Pharmacist on a monthly visit. Monitoring of the form will be done by the Q.I. team.
- B. Narcotic Log
A count will be done on all schedule II, III, IV, & V narcotics at the beginning and end of each day the center is open. Discrepancies will be resolved if possible. If the discrepancy can not be resolved, an incident report will be completed and submitted to the Q.I. team for further investigation.
- C. Occurrence Report
All incidents involving medication administration will be submitted to the Q.I. team for review.
- D. Medication Error Log
All medication incidents will be recorded according to type for monitoring, education and risk management purposes.
- E. Adverse Reaction Log
All adverse reactions will be recorded with subsequent follow-up. Pharmacy consultant will be notified with copy of form sent to consultant.

Percentage Monitored:

100% of all incidents involving the administration of medication will be reviewed and all schedule II, III, IV, V narcotics will be accounted for appropriately.

Frequency:

- A. Pharmacy Review- monthly
- B. Narcotic Log- Twice daily
- C. Occurrence Report – as needed.
- D. Medication Error Log – as needed
- E. Adverse Reaction Log – as needed

Threshold:

100% of all schedule II, III, IV & V narcotics will be documented appropriately and all incidents involving the administration of medication will be reviewed and processed accordingly.

Follow-up:

The Q.I. Committee will assimilate all data and report to the Q.I. meetings. The Q.I. Committee will also address and in-service the staff accordingly and report to MEC and Board of Directors as needed.

5. **CANCELLATION ON THE DAY OF SURGERY**

Tool:

A. Same Day Cancellation

This will be documented on an occurrence report and in HST by the staff member notified of the cancellation. Monitoring and assimilation of the documentation will be done by the Q.I. committee.

B. Cancellation Log

This form is filled out to summarize the reasons for cancellations. It enables the center to monitor the cancellations and define actions that may be necessary to avoid some of the same day cancellations.

Percentage Monitored

100% of cancellations on the day of surgery.

Frequency:

Monthly

Threshold:

100% of cancellation on the day of surgery will be followed for opportunities to avoid cancellations.

Follow-up:

The Q.I. committee will forward results of cancellations monitoring to the Q.I. Committee who will follow up accordingly.

6. **MEDICAL RECORD REVIEW**

- ❖ The results of peer review are used as part of the basis for granting continuation of clinical privileges.

Tool:

A. Daily Chart Review

This form will be completed on all patient charts. It will be utilized to verify the chart is put together in the correct order and that it is complete.

B. QI Chart Audit

This form will be completed on 10% of all completed procedures, representing every specialty. It will enable us to monitor many aspects of the completeness of the Medical Record, in addition to confirming the medical necessity of the procedure done. Results will be made available to the Q.I. Committee.

C. Incomplete Health Record Report

This form will be completed on all medical records that are delinquent past 30 days despite center attempts at completion. The report will be forwarded to the MEC and the Governing Body for further action.

Percentage Monitored:

1. QI Chart Review – 100% - all patients
2. Chart Audit – 10% of all procedures.
3. Incomplete Health Record Report – 100% of all delinquent charts.

Frequency:

1. QI Chart Review – monthly
2. Chart Audit – monthly
3. Incomplete Health Record Report – monthly

Threshold:

100% of medical records reviewed will be completed as required by law and Surgery Center Medical Staff Bylaws.

Follow-up:

Any matter that renders a chart incomplete will be appropriately addressed by the Q.I. Committee and forwarded to the MEC and Board of Directors.

7. SAFETY

Tool:

- A. Record of Safety Rounds
This form is completed by the Safety Committee to ensure accepted standards of safety are being utilized. Noncompliance will be addressed with personnel involved and according to the Center Safety Management Plan.
- B. Occurrence Report
This form is completed by any staff member whenever a potential safety concern is noted. It is forwarded to the Safety Committee/QI Committee who ensures resolution of the concern.
- C. Emergency Drill Records & Summary
These forms will be completed by the Safety Officer to evaluate compliance of center emergency preparedness and reports to QI Committee

Percentage Monitored:

100% of all safety concerns.

Frequency:

- A. Record of Safety Rounds - monthly
- B. Occurrence Report – on going
- C. Emergency Drill Records & Summary – quarterly

Threshold:

100% of all reported safety issues will be addressed and resolved

Follow-up:

The Safety/QI Committee reviews any deficiencies with the staff and implements changes as needed. If safety issues are due to staff noncompliance, those individuals involved will be counseled.

8. INFECTION CONTROL

Tool:

- A. Infection Report Form
This form will be completed on all cases of infection and will be referred to the Q.I. team for surgical case review.
- B. Infection Log
In order to track post-op infections through the physician's office, a letter will be mailed/faxed to physicians along with a list of their patients who had procedures. If the physician fails to respond, a second letter will be sent. After two unsuccessful attempts, the physician will be contacted via phone. All cases of infection will be investigated and reported to the staff and the Q.I. Committee.
- C. Infection Summary
This form will be used to summarize the number of post-op infections and percentage of reports returned.
- D. Sterilization Report
This form will be used to summarize the sterilization performance and report any positive biologicals.

Percentage Monitored:

- A. Infection Report Form- 100% of all cases that develop a post-op infection.
- B. Infection Log- 100% of the physicians who have completed procedures.
- C. Infection Summary- 100% of infections
- D. Sterilization Report- 100% of all positive biologicals will be reported

Frequency:

Monthly

Threshold:

100% of all reported infections will be investigated.

Follow-up:

Results of the indicator will be presented at the monthly staff meetings and at the Q.I. meeting. All cases of post-op infections will be discussed to determine appropriate systems corrections and preventive measures that may be deemed necessary and reported to MEC Committee, Board of Directors.

9. CREDENTIALS

Tool:

Credentialing Checklist

This form will be completed by the Medical Staff Credentialer to assure proper credentials are maintained by all physicians at the Surgery Center.

Credentialing Report

This form will be used to summarize the credentialing status of physician files to the Medical Director, MEC and ultimately the Board of Directors.

Percentage Monitored:

100% of all physicians and Allied Health Professionals

Frequency:

On-going

Threshold:

100% of the Surgery Center credentialed physicians and Allied Health Professionals will have the required current documents.

Follow-up:

Specific credentialing difficulties will be referred to the Medical Director, Administration, and if necessary the Q.I. Committee and the Board of Directors.

10. EMPLOYEE FILES

- ❖ All health care professionals have the necessary and appropriate training and skills to deliver the services provided by this organization.
- ❖ Health care professionals practice their professions in an ethical and legal manner.
- ❖ All personnel assisting in the provision of health care services are appropriately trained, qualified, and supervised and are available in sufficient numbers for the care provided.

Tool:

A. Employee File Checklist

This form will be maintained by the Manager for all employees in each employee file.

B. Employee Competency Record

This form is completed by the department manager to ensure strong knowledge and competency by all staff personnel.

C. Performance Review

This form will be completed by the department manager on an annual basis in order to document the employee's job performance.

Percentage Monitored:

100% of all employees

Frequency:

- A. Employee File Check List – initial hiring
- B. Employee Competency Record – on going
- C. Performance Review – annual

Threshold:

100% of employee files will have current proof of compliance as required by Surgery Center and State/Federal Regulations.

Follow-up:

Specific employee file difficulties will be referred to the Administrator if necessary.

11. ANCILLARY SERVICES

Tool:

- A. Glucose Monitoring Form
This form will be complete by the Laboratory consultant on a monthly basis. Monitoring of the form will be done by the Q.I. team.
- B. Pathology Review Checklist
This form will be utilized to record findings of pathology reports received and assure reporting to physician.
- C. Tissue Review Report
This form will be used to summarize tissue reporting.
- D. Annual Review of Lead Protection Devices
This form will be complete by the Radiology technician annually. Monitoring of the form will be done by the Q.I. team.

Percentage Monitored:

100% of all laboratory test & Radiology safety procedures.

Frequency:

- A. Glucose Monitoring results- monthly
- B. Pathology Review Checklist - quarterly
- C. Tissue Review Report- quarterly
- D. Review of Lead Protection Devices - Annual

Threshold:

100% of all glucose tests will be correctly performed and reported appropriately & Radiology safety procedures followed.

Follow-up:

The Q.I. team will assimilate all data and report to the Q.I. meetings. The Q.I. team will also address and in-service the staff accordingly.

12. Blood Borne Pathogens Exposure

Tool:

- A. Occurrence Reports
 - This form will be completed by the staff member involved with assistance from clinical Manager.
 - Employee will be sent for emergency treatment of exposure deemed significant. Concentra clinic will do follow up as needed on our employees.

- B. BBP exposure form
 - Employee Exposure
 - Patient consent

Percentage Monitored:

100% of all employee exposures

Frequency:

- A. Occurrence report ongoing
- B. BBP exposure report ongoing
- C. Annual report posted per OSHA guidelines

Threshold:

100% of employee exposures will be followed as appropriate

Follow-up:

The Q.I. team will assimilate all data and report to the Q.I. meetings. The Q.I. team will also address and in-service the staff accordingly.

Quality Improvement Reporting Schedule

The following matrix outlines the quarterly Quality Improvement Reports to the Q.I. Committee, Medical Executive Committee and Board of Directors. The reports are due in the month or quarter indicated based on data collated from the immediately preceding months. The Quality Improvement Committee will report to the MEC through the Administrator. Recommendations from the MEC and Board of Directors will be reported back to the QIC and or MEC through the Administrator.

Quarter	Report	Responsibility for Data
Every Month	QI Meeting Summary	D.O.N./ Administrator
	Infection control statistics	
	Pharmacy audits	
	Patient/Employee/Physician Satisfaction	
	Cancellation DOS	
	Sterilization Reports	
	Occurrence Reports/Patient Complications	
	Chart Review	
	Pathology/Laboratory	
	Extended Recovery Unit	
	Medication Errors & Adverse Drug Reactions	
	Physician Utilization Review	
	Quality Improvement Projects	
	Safety Reports	
	Peer Review/Credentialing	
Annual	Policies & Procedures	Administrator
	Infection Control Plan	
	Local Contracts	
	Quality Improvement/Risk Management Plan	
	Review Annual Marketing Plan	
	Annual Report to the Medical Staff	
	Annual Safety Program Summary	
	Employee Performance	
	Review/Approval Annual Budget	

Southern Hills Hospital and Medical Center

Patient Safety Plan

Updated: February 5, 2018

Quality of Care Committee: March 15, 2018

Medical Executive Committee: March 15, 2018

Board of Trustee: 3/22/2017 March 21, 2018

2018 PATIENT SAFETY PLAN

TABLE OF CONTENTS

INTRODUCTION	3
POLICY	7
CULTURE OF SAFETY	8
STRUCTURE, ROLES AND RESPONSIBILITIES	8
MECHANISMS FOR COORDINATOR	11
<u>COMMUNICATING WITH PATIENTS ABOUT SAFETY</u>	12
EDUCATION	13
SAFETY IMPROVEMENT ACTIVITIES	13
REPORTING PATIENT SAFETY RESULTS	15
ANNUAL REVIEW.....	16
REFERENCES/AUTHORITY	16
APPENDIX ONE PSC 2018 GOALS	17
APPENDIX TWO 2018 INFECTION PREVENTION PLAN	18

I. **Introduction**

Purpose, Scope and Responsibility

- ✓ Purpose:
 - To define the essential components of the Patient Safety Program at Southern Hills Hospital, which is committed to ensuring a safe environment and reliable care processes.
 - To cultivate a culture of patient safety through the ongoing promotion of a safe practices and personal accountability.
- ✓ Scope: Patient safety is everyone's responsibility. The Southern Hills Hospital Patient Safety Program covers all activities and functions relating to patient safety at all sites and services within the organization.
- ✓ Responsibility: Leaders, employees, members of the medical staff, students and volunteers are to be familiar with and involved in the Patient Safety Program.

Participation in Patient Safety Organization

- ✓ Southern Hills Hospital is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided to the Hospital. To further this objective, the Hospital contracted with HCA Patient Safety Organization, LLC ("HCA PSO, LLC"), a federally certified Patient Safety Organization ("PSO"), to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.
Generally speaking, patient safety work product ("PSWP") is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act ("FOIA"), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act ("PSQIA") and its associated regulations. *(See 42 CFR § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.)*
The Hospital will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses, patient safety communications, quality reviews, and other documents aimed at improving patient safety. Documents will be submitted in a standardized format to allow for comparison with like providers. As part of this effort, the Hospital will operate a Patient Safety Evaluation System ("PSES") designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC. The PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes. Designated Hospital personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

Definition of Terms

Accountability:

An obligation or willingness to accept responsibility for one's actions.

<u>Adverse Event:</u>	Event under the control of a provider which has caused harm and requires a new or modified physician order for management of the patient's health care. See Policy RM19: Sentinel Event for specific event list and RM13: Disclosure of Adverse Events.
<u>Hazardous condition:</u>	Any set of circumstances (exclusive of the disease or condition in which the patient is being treated), which significantly increases the likelihood of serious adverse outcome.
<u>Healthcare FMEA:</u>	Healthcare Failure Mode and Effects Analysis: A proactive model for addressing potential risks within the organization.
<u>Human Error:</u>	An unintended act, or failure to act, that results in actual or potential patient injury, harm or adverse event in the process of care delivery.
<u>Near miss:</u>	Any process variation that did not affect the patient outcome, but for which a recurrence carries a significant chance of serious adverse outcome.
<u>Non-punitive:</u>	No punishment or disciplinary action imposed for specific error.
<u>Patient injury:</u>	Major permanent loss of function, sensory, motor, or intellectual impairment not present at admission, requiring continued treatment or lifestyle change. When "major permanent loss of function" cannot be immediately determined, patient injury is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

Patient safety event:

All adverse events or potential adverse events that are deemed preventable and Healthcare associated infections as defined by the CDC that are deemed to be preventable.

PSQIA

The Patient Safety and Quality Improvement Act (PSQIA) of 2005, Pub. L. 109-41, 42 U.S.C. 299b-21-b-26 (for which the final rule implementing the regulations became effective on January 19, 2009), was enacted in response to growing concern about patient safety in the United States and the Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System*. The goal of the Act is to improve patient safety by encouraging voluntary and confidential reporting of events that adversely affect patients.

PSO

A Patient Safety Organization (PSO) means a private or public entity or component thereof that is listed as a PSO by the Secretary of Health and Human Services. A health insurance issuer or a component organization of a health insurance issuer may not be a PSO. The PSO enters into bona fide contracts, each of a reasonable period of time, each with a different provider for the purpose of receiving and reviewing patient safety work product.

PSES

A Patient Safety Evaluation System (PSES) means the collection, management, or analysis of information for reporting to or by a PSO.

PSWP

Patient Safety Work Product (PSWP) (1) Except as provided in (2) below, patient safety work product means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material) (i) Which could improve patient safety, health care

quality, or health care outcomes; and (A) Which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO, and such documentation includes the date the information entered the patient safety evaluation system; or (B) Are developed by a PSO for the conduct of patient safety activities; or (ii) Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system. (2)(i) Patient safety work product does not include a patient's medical record, billing and discharge information, or any other original patient or provider information; nor does it include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a PSO shall not by reason of its reporting be considered patient safety work product. (ii) Patient safety work product assembled or developed by a provider for reporting to a PSO may be removed from a patient safety evaluation system and no longer considered patient safety work product if: (A) The information has not yet been reported to a PSO; and (B) The provider documents the act and date of removal of such information from the patient safety evaluation system. (iii) Nothing in this part shall be construed to limit information that is not patient safety work product from being: (A) Discovered or admitted in a criminal, civil or administrative proceeding; (B) Reported to a Federal, State, local or Tribal governmental agency for public health or health oversight purposes; or (C) Maintained as part of a provider's recordkeeping obligation under Federal, State, local or Tribal law.

Reliability:

The extent of consistent performance over time.

Sentinel Event: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, and/or severe temporary harm (TJC, 2016). (A permanent loss of function related to the natural course of the patient's illness or underlying condition is not a Sentinel Event.) The State of Nevada defines a sentinel event as an event included in Appendix A of "Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report," published by the National Quality Forum (Nevada Revised Statutes NRS §439.830 – effective October 1, 2013).

Sentinel Event Alert Gap Analysis: A model for prioritizing and addressing potential risks related to publish external sentinel or warning alerts.

Unusual Occurrence: Any event or condition not consistent with the normal or usual operation of the hospital or department and which has the potential for causing patient or visitor injury or property damage.

II. Policy

The Board of Trustees delegates responsibility for oversight of the patient safety program to the Quality Care/Patient Safety Committee. The Quality Care/Patient Safety Committee monitors and evaluates the effectiveness of the Patient Safety Program and generates feedback and actions as appropriate. The Quality Care/Patient Safety Committee prepares a quarterly report to the Quality Care/Patient Safety Committee, Medical Executive Committee (MEC), and the Board of Trustees (BOT). The report includes at a minimum, occurrence or trending of patient safety indicators and actions taken in response to actual occurrences as well as proactive assessments of high-risk activities. The Environment of Care Committee oversees non-clinical safety related processes and system issues that affect patients, employees, and visitors in the environment of care.

Risk Management maintains the hospital-wide occurrence reporting system for patients, employees, and visitor occurrences and a referral system for hospital staff and

physicians to report potential claims. Risk Management in conjunction with Hospital Quality and Patient Safety Leaders investigate actual and potential safety risk within the organization. They also evaluate occurrences to identify those that may require immediate follow up actions or meet the Sentinel Event, the Safe Medical Device Act, or regulatory agency reporting criteria, including CMS, FDA, OSHA, State of Nevada DHHS, or Joint Commission. Notification is made to Administration, Risk Management, appropriate regulatory and accrediting agencies, equipment manufacturers and other appropriate individuals as necessary.

The Organization ensures timely coordination and dissemination of reporting and data management of patient safety information at the appropriate medical staff/organizational committees for review and discussion.

III. Culture of Safety

Southern Hills Hospital is committed to creating a culture of safety by designing or redesigning systems and processes geared to prevent, detect, and minimize the hazards and likelihood of error. Southern Hills Hospital is focused on prevention, not blaming individuals. Patient safety events are viewed as an opportunity to learn. The Hospital believes in balancing the organization's accountability and the individual's accountability for assuring safe practices and a safe environment to care for patients.

IV. Structure, Roles and Responsibilities

The philosophy guiding the promotion of a culture of patient safety is accountability. To achieve a culture of patient safety the following accountabilities are expected at Southern Hills Hospital:

Role	Accountability	Specific Tasks
Board of Trustees, with Senior Leadership	Set goals, monitor performance & require accountability.	<ul style="list-style-type: none"> • Receive regular and thorough reports on patient safety risks, hazards and progress towards performance improvement objectives from the MEC and Patient Safety Committee. • Receive regular and thorough briefings regarding the results of culture measurement and performance improvement initiatives • Require multi-cause analysis of errors that lead to injury. • Set performance improvement goals for safety improvement. • Hold hospital leaders accountable for achieving the integrated patient safety agenda. • Receive systematic and regular assessment of resource and budget allocations to key systems (patient safety systems, human resources, quality systems, technology) related to the patient safety agenda.
Administrative (CEO, COO, CNO, VP's, Directors, & Physician Leaders)	Set the agenda for the rest of the team	<ul style="list-style-type: none"> • Ensure that an integrated patient safety program is implemented throughout the hospital. • Set performance improvement priorities and identify how the hospital adjusts priorities in response to unusual or urgent events. • Allocate adequate resources for measuring, assessing and improving the hospital's performance and improving patient safety. • Measure and assess the effectiveness of the performance improvement and safety improvement activities. • Monitor implementation for of corrective action of patient safety events. • Ensure remedial activities, identified through analysis of reported patient safety events, are implemented, effective, and do not cause unintended adverse consequences. • Develop a proactive approach to reducing errors. • Encourage an environment of openness & collaboration. • Support a dialogue about outcomes between patients and clinicians including systems to obtain direct feedback from patients regarding performance of the organization • Educate staff about safety. • Support staff and lead by example.

Role	Accountability	Specific Tasks
Patient Safety Officer	Lead patient safety initiatives with the medical staff and organizational staff	<ul style="list-style-type: none"> • Lead an integrated patient safety program. • Serve as the primary point of contact for questions about patient safety, and coordinate patient safety for education and deployment of system changes. • Execute performance improvement priorities and adjusts priorities in response to unusual or urgent events. • Assure effectiveness in measuring, assessing and improving the hospital's performance and improving patient safety. • Lead a proactive approach to reducing errors and make recommendation to reduce patient safety events. • Lead in an environment of openness & collaboration. • Assure dialogue about patient safety issues occurs effectively between patients and clinicians. • Report progress regularly, and educate about patient safety • Support staff and lead by example.
Quality Coordinators	Day to day coordination and facilitation of safety initiatives	<ul style="list-style-type: none"> • Implement operational aspects of the patient safety program throughout the hospital. • Implement proactive patient safety management that assures immediate, appropriate response to unusual or urgent events. • Participate in measuring, assessing and improving the hospital's performance and improving patient safety. • Be accountable for patient safety initiatives and strengthening a culture of safety in day to day practice. • Support an environment of openness & collaboration. • Support a dialogue about patient safety issues between patients and clinicians. • Report progress regularly, and educate about patient safety. • Support staff and lead by example.
Pharmacists	Ensure safe medication usage	<ul style="list-style-type: none"> • Ensure that authoritative, up-to-date drug information is available in reference form in patient care areas and prescribers' offices. • Periodically examine all drug products stored in patient care areas and procedures on drug storage/distribution to patient care areas. • Minimize the need for nurses to calculate, manipulate, or mix medications. • Establish a pharmacy led interdisciplinary team to spearhead medication safety activities. • Provide leadership to develop safe medication delivery systems.

Role	Accountability	Specific Tasks
Clinicians & Medical Staff	Monitor, report, & learn.	<ul style="list-style-type: none"> • Medical staff and other employee job descriptions and competency evaluations incorporate accountability for safety. • Medical staff & employees participate in education on the importance of safety, surveillance, and expectations for reporting safety concerns, beginning with orientation. • Medical staff & employees evaluations include an individual's contributions to safety for the organization. • Medical staff & employees are positively acknowledged for disclosing errors, near-misses, and safety concerns. • Employees and physicians work collaboratively assuring responsibilities of the team to the patients are met, and noticing errors before they cause harm. • Participate in the facility reporting system for PS events, both actual and potential event.
Patients/visitors	Involved partners in prevention.	<ul style="list-style-type: none"> • Inform doctors and nurses about medications they take, including prescriptions, over-the-counter drugs and dietary supplements. • Ask for written information about possible side effects. • Inform the doctors and nurses about allergies & adverse reactions. • Ask a relative or friend to be an advocate. • Learn about their medical condition by asking their doctor, nurse, and other reliable sources. • Upon hospital discharge, ask doctors for an explanation of the treatment plan to be used at home. • Provide feedback regarding performance of the organization • Report safety concerns through the Patient Safety hotline and other venues available.

V. Mechanisms for Coordination

Southern Hills Hospital Patient Safety Committee

The SHH Quality Care/Patient Safety Committee (QC/PSC) or equivalent is a multidisciplinary team involving department representatives that meets ~~not less than~~ monthly. The Quality Care/Patient Safety committee or equivalent committee, is comprised of various health care professionals including but not limited to physicians, nurses, pharmacists and administrators, and is chartered to oversee the implementation of the Hospital's Patient Safety Program. The Patient Safety Officer coordinates activities within the Patient Safety Program.

Structures that support the QC/PSC or equivalent works in conjunction with other safety committees, including but not limited to:

- Medication Safety

- Quality Council
- Environment of Care
- Falls Committee
- Infection Prevention Committee

The QC/PSC reviews and develops implementation strategies for the NPSG's. Strategies include assessing and developing a culture of patient safety, encouraging a non-punitive reporting environment, developing a best practice infrastructure to foster the design of safety into our systems, and monitoring of systems risks and improvements. The QC/PSC networks with other committees as appropriate per topic to gain consensus (e.g. Quality Care Committee, Infection Prevention, Pharmacy, other). Sentinel Event Alerts and other industry alerts are routed to the appropriate committee or teams to ensure evaluation of current care processes incorporate recommended changes.

The PSC VP of Quality/Risk Management and the Patient Safety Officer reviews Sentinel Event Alerts, other industry alerts, compliance to The Joint Commission National Patient Safety Goals, State regulatory requirements, adverse events and potential adverse events that are deemed to be preventable, health care associated infections as defined by the CDC that are deemed to be preventable, and assures recommendations are integrated into processes. Additional resources such as national and local professional organizations/associations are monitored for changes in standards and potential risk events. Regular summary reports of progress are reported to the designated Quality Care Committee, Medical Executive Committee, and the Board of Trustees.

The QC/PSC reviews and approves plans to address key organizational concerns, such as Falls, Restraint Reduction, Patient/Family Education, Patient Mobility, Blood and Blood Components, Medication Safety, Adverse Drug Reactions (ADR's), Pressure Ulcer Prevalence, Health Care Associated Infections and Environmental issues updates.

The QC/PSC recommends and provides direction for training on key initiatives and educational strategies related to patient safety.

VI. Communicating with Patients about Safety

It is Southern Hills Hospital's philosophy that accountability for patient safety is imbedded in a collaborative relationship involving our Board of Trustees, administrative leadership, our medical staff, employees, patients and family.

Patient safety awareness information is posted in public areas throughout the hospital. This information contains basic strategies for patients to assist in assuring their safety. The admission and discharge patient information also contains information on the patient role in safety. Patient Guides are provided to in-patients upon admission, and includes strategies prevent untoward events such as falls, medication errors, and infections while in the hospital. Annually, Patient Safety Awareness Week activities are planned to educate and inform staff, patients and the community. The Southern Hills Hospital

consumer web page also includes access to an electronic version of the Patient Guide. Information and additional resources are provided to assure patient involvement in their care.

Patients or their families may contact the hospital to report patient safety concerns as well as to the State of Nevada Department of Health and Human Services or to the Joint Commission. The hospital's website and other patient materials include information on how to report issues internally as well as to the Joint Commission.

Patients are randomly selected to participate in completing the Patient Experience Survey after discharge, which include questions related to the patient safety experience. These results are reported to the hospital.

VII. Education

1. Staff Education

- General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety
- Specific Patient Safety Program training at orientation and annually thereafter will include:
 - An overview of the Patient Safety Program
 - Staff's role and responsibilities in the Patient Safety Program
 - Event reporting, including the events requiring reporting and the process for reporting events.
 - Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care;
 - Examples of specific job-related aspects of patient safety.

2. Physician Education - An overview of the Patient Safety Program is provided to physicians at time of initial appointment and periodically thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism and Culture of Safety processes.

3. Organizational Learning: Patient safety is everyone's responsibility. Everyone has a responsibility to report. By reporting concerns, it enables the organization to learn and improve processes, procedures, and systems.

VIII. Safety Improvement Activities

Prioritization of Patient Safety Activities

Prioritization elements are defined in the annual performance improvement plan and apply to patient safety initiatives. The QC/PSC annual goals are listed at the end of this plan and meet the prioritization elements.

Routine safety-related data collection analysis

- Unusual Occurrence reporting (see SPAE Guidance Policy)
- Medication Error Reporting
- Infection Surveillance
- Culture of Patient Safety Survey
- Environmental Safety Rounds and Assessment
- Patient Experience Survey
- Leadership Walk-around and Tracers
- National Patient Safety Goal Dashboard
- Annual Leapfrog (NQF Safe Practices) Survey
- Sentinel Event Alert Compliance
- Institute for Safe medication Practices(ISMP) and other industry Alerts
- Employee feedback survey

Identification, reporting, and management of patient safety events

1. To effectively improve processes and systems, health care providers should not be fearful of punishment or retribution for reporting mistakes.
2. An accessible multifaceted non-punitive, just culture reporting system exists .
3. Errors and accidents are tracked in an attempt to establish trends and patterns, to learn from them and prevent reoccurrence.
4. Healthcare providers participate in reporting and developing improved processes to effectively evaluate errors and near misses.
5. Reporting errors and near misses are a critical component of the Southern Hills Hospital Patient Safety Program.

The Meditech on-line incident reporting system is a tool for the documentation, investigation, and correction of patient safety issues as described in the organizational policy: The Patient Safety Director coordinates this process.

Organization or Medical Staff committees refer patient safety issues to the Patient Safety Officer for review at the PSC and corrective action.

NRS 439.877 – Monitoring and Compliance

Nevada statute NRS 439.877 requires medical facilities to adopt patient safety checklists and patient safety policies. These patient safety checklists are protocols used to improve the outcomes of patients at the hospital to include:

1. Patient Discharge Process-Healthy Living (Meditech)
2. Patient Identification Process (Policy)

3. Patient room/environment sanitation and cleaning (Sodexo 7-Step Cleaning Process)
4. Additional patient safety checklists which may be appropriate to ensure the safety of patients in the facility. These include, but are not limited to the following:
 - a. Universal Protocol (Safe Procedural and Surgical Verification)
 - b. Central Line Insertion Bundle (Meditech)
 - c. Hand Hygiene (Audit Checklist)

Monitoring and oversight for compliance with these policies and checklists will be the ongoing responsibility of the Quality Care/Patient Safety Committee.

NRS 439.865– Infection Control Program

Nevada statute NRS 439.865 requires medical facilities have an infection control program to prevent and control infections within the medical facility, as well as an infection control policy. The Hospital's Infection Control Plan is attached as an addendum to the Patient Safety Plan and is reviewed annually. (See Appendix 2 – Infection Prevention and Control Plan)

Proactive Risk Identification and Reduction:

1. Opportunities for improvement regarding patient safety issues and hazardous conditions are identified through trending of actual or potential occurrences involving patients or visitors and/or evidence-based literature (e.g. The Joint Commission Sentinel Event Alerts).
 2. When an identified opportunity for improvement is identified, it is analyzed by the involved care providers according to level of severity, frequency of occurrence, potential for harm and liability.
 3. At least every 18 months, one high-risk or error-prone process is selected for Failure Mode Effect Analysis (FMEA) process. The underlying systems are examined and modified or redesigned to minimize the risk of the identified failure mode.
 4. Trending of adverse events, environmental safety issues, aggregate data collection, and review of intensive assessments are part of the identification and management of risks to safety and are used to prevent reoccurrences.
 5. Serious unusual occurrences and sentinel events are reviewed with determination made for intensive assessment and root cause analysis according to the SPAE policy.
 6. Near miss events are reviewed and root cause analysis conducted as deemed appropriate.
 7. Regular communication about patient safety and risk management is conducted with designated Quality Care Committee, Medical Executive Committee, and the Board of Trustees.
- Disclosure of an adverse event to a patient is in accordance with the SPAE policy.

IX. Reporting Patient Safety Results:

To the QC/PSC:

The Quality Care/Patient Safety Committee reviews and recommends actions on the following reports:

- Audits and performance improvement activities on Patient Safety
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Culture of Patient Safety Survey
- Leapfrog Survey

To organization staff and medical staff:

Organizational staff receives patient safety results and information on:

- Culture of Safety Survey
- Patient experience survey results on patient safety components.
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Leapfrog Survey

To executive leadership and Board of Trustees:

The Board of Trustees and Executive Leadership receives periodic reports on:

- Culture of Safety Survey
- Leapfrog Survey
- Results of intensive analyses related to patient safety issues

X. Annual Review

The Patient Safety Program is reviewed annually and revised as necessary. It is submitted annually for review and approval by the Medical Executive Committee and the Board of Trustees.

XI. References/Authority

- The Joint Commission 2018 NPSG's
- HCA Patient Safety Organization PSO Operating Policy and Procedure
Federal Register- Department of Health and Human Services 42 CFR Part 3
Patient Safety and Quality Improvement

Appendix One

Strategic Priorities for 2018 - Goals

- Complete AHRQ Culture of Safety Survey with \geq 80% participation
- Kick-off of Non-punitive reporting program with recognition of a minimum of one employee; four appreciation opportunities throughout the year
- Implement weekly Executive Leader Safety Briefs and Rounds
- Achieve 95% compliance with oxytocin process measures each quarter Q417 – Q318.
- Create facility-wide expansion and implementation plan for use of SBAR tool on all clinical high-risk areas and perform SBAR Hand-off Point Prevalence Audit
- 95% of leadership and staff complete viewership of “Hindsight” educational videography by end of Q318
- 95% of new hires from January 1-September 30, 2018 complete viewership of “Hindsight” educational videography by end of Q318
- Complete and submit a minimum of 4 Serious Event Analyses (SEAs) to the PSO
- Submit a 3 case studies from completed SEAs to the PSO
- Submit 95% of all patient event and close call reports designated as PSWP within 60 days
- Submit Patient Fall Monthly Reconciliation Report
- Participate in 80% of the Division-wide Patient Safety Table project
- Weekly Executive Leader Safety Briefs
- Implement Daily Nursing Safety Debriefs
- Attend Patient Safety Director Development Program
- Obtain/maintain CPPS/CPHRM Certification
- Attend HCA PSO Seminar
- Attend National Patient Safety Foundation Patient Safety Congress

Appendix Two

[Link to Infection Prevention and Control Plan](#)

Policy Title: 2018 Patient Safety Plan

Audience: All Employees

References and Citations:

PURPOSE

The purpose of the Patient Safety Plan is to provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services. The goal of the Patient Safety Plan is to provide a safe environment for patients and their families. The approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at the Hospital. The purpose includes creating an environment that encourages:

- Recognition and acknowledgment of risks to patient safety and medical/health errors;
- The initiation of actions to reduce these risks;
- The internal reporting of what has been found and the actions taken;
- A focus on processes and systems;
- Minimization of individual blame or retribution for involvement in a medical/healthcare error;
- Organizational learning about medical/healthcare errors;
- Support of the sharing of that knowledge to effect behavioral changes in itself and other health care organizations; and
- Disclosure of the outcomes of care, treatment and services.

The Patient Safety Plan developed by the interdisciplinary Patient Safety Committee and approved by the Medical Executive Committee, and the Board of Trustees, outlines the components of the organization-wide Patient Safety Program.

SCOPE OF ACTIVITIES

The Patient Safety program is an organization-wide program that includes and integrates all activities within the organization and CHS PSO, LLC. which contributes to the maintenance and improvement of patient safety, healthcare quality and healthcare outcomes.

The scope of the Patient Safety Program involves an ongoing assessment, using internal and external knowledge and experience, to prevent occurrence of errors and to maintain and improve patient safety. Patient safety event information from aggregated data reports and individual event reports will be reviewed by the Patient Safety Committee to prioritize organizational patient safety activity efforts.

In addition to internal knowledge and experience, the services and information that the CHS PSO, LLC. offers will be reviewed and evaluated to include:

- Best Practices and Took Kit Development;
- Comparative Analysis of Adverse Event Reported in the Event Reporting System;
- Unsafe Behavior Evaluations;
- Raise safety awareness through the internal publication of anonymized Action Plans from root cause analysis;
- Develop and publish Patient Safety Alerts; and
- Monthly Comprehensive Risk Assessments.

Patient Safety Event Work Product:

Types of patient safety events, adverse outcomes, or medical/health care errors included in data analysis are:

- Event Reports- those events and outcomes reportable to the Director of Risk Management by an Event Report (Form RM 3301) during downtime or by entering the occurrence into the Event Reporting System include processes and outcomes of care that may result in no harm through serious injury or death. Examples include falls, medication variances, adverse drug reactions, intravenous therapy variances, procedure variances, procedure complications, patient complaints and AMA and elopement discharges. These may also include near miss events.
- Hemolytic transfusion reactions reported through the transfusion review channels.
- Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Serious Safety Event & Sentinel Event: applies to events that have resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition. In addition, there are other event types that are considered sentinel due to the severity of the event even though the outcome was not death or permanent loss of function unrelated to the natural course of the patient's illness or underlying condition.
- Serious Safety Event & Sentinel event criteria and the procedures involved are detailed in the sentinel event and root cause analysis policies and procedures including definitions of near misses, which require a root cause analysis.
- Never Events and Hospital Acquired Conditions including:

Surgical events:

- Surgery performed on the wrong body part;
- Surgery performed on the wrong patient;
- Wrong surgical procedure performed on a patient;
- Unintended retention of a foreign object in a patient after surgery or other procedure;
- Intraoperative or immediately postoperative death in an American Society of Anesthesiologists Class I patient; or
- Artificial insemination with the wrong sperm or donor egg

Product or device events:

- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility;
- Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used for functions other than as intended; or
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility e.g., luer connectors are implicated in or contribute to many of these errors because they enable functionality of dissimilar tubes to be connected.

Patient protection events:

- Infant discharged to the wrong person;
- Patient death or serious disability associated with patient elopement (disappearance); or
- Patient suicide or attempted suicide resulting in serious disability, while being cared for in a health care facility

Care management events:

- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration);
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products;
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility;
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility;
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates;
- Stage 3 or 4 pressure ulcers acquired after admission to a health care facility; or
- Patient death or serious disability due to spinal manipulative therapy

Environmental events:

- Patient death or serious disability associated with an electric shock or electrical cardio-version while being cared for in a health care facility;
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility;
- Patient death or serious disability associated with a fall while being cared for in a health care facility; or
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility.

Criminal events:

Original Effective Date: 9/30/2004

Revision Date: 8/31/2018

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- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
 - Abduction of a patient of any age;
 - Sexual assault on a patient within or on the grounds of the health care facility;
 - Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the health care facility; or
 - Environment of care significant incidents involving employee, visitor, utility or property damage

Sources of external knowledge and experience include the Sentinel Event Alerts. Published by The Joint Commission, safety alerts published by the Food and Drug Administration, Patient Safety Alerts, adverse outcome and lessons learned from RCA's, information from insurance carriers and other private and public healthcare safety organizations.

The scope of the organization-wide Safety Program encompasses all people including the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility, as well as employee safety, physical plant and facilities, equipment and supply-related safety issues, among other safety issues. To promote efficiency, there is an Environment of Care Committee, chaired by the Environmental Safety Officer, that addresses employee events and safety, workers compensation, needle sticks and products, visitor Events, hazard surveillance, and the safety management plans. To promote integration, communication and analysis of inter-related issues, there is cross membership between the committees, and both committees report to the Quality Improvement Council for oversight and further integration of related issues. Physician peer review of medical errors is also conducted at the Quality Improvement Council level (or at their direction).

The Serious Safety Event Rate (SSER) calculation will then be reviewed on a monthly basis. The SSER should be considered Patient Safety Work Product and will be reported to the following council/committees, Patient Safety, Medical Executive and the Board of Directors. This rate will also be reported to the Patient Safety Committee and the CHS PSO.

The Patient Safety Committee is composed of a physician chairperson. Other members include the Chief Quality Officer/QMRC, administrative representation such as the assistant CEO or COO, nursing leadership representative(s), including hospital, a pharmacist, and appropriate other medical and organization staff.

The meeting frequency should be held quarterly. The Patient Safety Committee will appoint a Patient Safety Officer. The organizations' Director of Risk Management will serve as the Patient Safety Officer in most instances.

Procedures

Committee responsibilities:

1. The interdisciplinary Patient Safety Committee is responsible for the oversight and management of the Patient Safety Program. This includes making recommendations to organization leaders regarding the adequacy of resources allocated to support patient safety activities. The committee will oversee data and analysis in order to prioritize patient safety activities, including, but not limited to patient safety work product, Medication Variances, Infection Surveillance, Safety Surveillance, Staff Perceptions of and suggestions for improving patient safety, Staff willingness to report errors (Employee Surveys), Patient/Family perceptions of, and suggestions for improving patient safety, and results of risk assessment surveys by department.
2. The Patient Safety Committee is responsible to review and approve the organization-wide and departmental patient safety-related policies, procedures and CHS PSO information. This should include the content of any proactive risk self-assessments prior to data collection, as well as patient/family education regarding their role in helping to facilitate the safe delivery of care.

All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences, and potential occurrences to the Director of Risk Management, who will aggregate occurrence information and present a report to the Patient Safety Committee on a monthly basis. This Patient Safety Work Product report will contain aggregated information related to the cause or nature of the occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, improvement actions taken, and patient outcome. The Patient Safety Committee will analyze the report information and determine further patient safety activities as appropriate. Any undesirable patterns or trends in patient safety and sentinel events should be intensively analyzed. Intense analysis involves studying a process to learn in greater detail about how it is performed or how it operates, how it can malfunction, and how errors occur.

3. Patient complaints and concerns or ideas about patient safety should be reported to and evaluated by the Patient Safety Committee. Patient safety information input regarding employee willingness to report and related information from patient and employee surveys should be reviewed and evaluated by the Patient Safety Committee. (Resolution of individual patient complaints is handled by the personnel so designated by the organization.)
4. The Patient Safety Committee reviews alerts or guidance from external sources, including TJC, Institute for Safe Medication Practices, the Food and Drug Administration and consider whether their recommendations should and could be implemented at the organization as a proactive measure to reduce patient safety risks.
5. Patient safety occurrences requiring a report to an external agency such the F.D.A., Board of Pharmacy, Center for Medicare Administration, a manufacturer or the state department of health, should also be reported to the Patient Safety Committee. This report should include an

analysis of the occurrence as to underlying causes, any improvement actions recommended and/or taken and, when available, the results of those improvement actions.

6. Through review of internal data reports and reports from external sources (including TJC sentinel event report information, and other sources such as available occurrence reporting information from state and federal sources and current literature), and through the Quality Improvement priority criteria grid, the Patient Safety Committee will select at least one high-risk safety process for proactive risk assessment annually using a Failure Mode Effects Analysis methodology.

The proactive risk assessment will include:

- ◆ Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation (failure mode). For each identified failure mode, identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be (criticality);
- For the most critical effects, conduct a root cause analysis to determine why the variation (failure mode) leading to that effect may occur;
- Redesign the process and/or underlying systems to minimize the risk of that failure mode or to protect patients from the effects of that failure mode;
- Test and implement the redesigned process;
- Identify and implement measures of the effectiveness of the redesigned process; and
- Implement a strategy for maintaining the effectiveness of the redesigned process over time.

Organization-wide activities:

1. Education regarding employee responsibilities for patient safety is included in initial and annual orientation programs, both by the Director of Risk Management and department manager. This includes reporting requirements and mechanisms. As appropriate, training which incorporates methods of team training to foster an interdisciplinary, collaborative approach to patient care delivery is provided. The Patient Safety Committee and other committees may recommend education as a patient safety improvement activity at any time throughout the year. Training on failure mode analysis, effects and criticality analysis should be done for those involved with this risk reduction tool.
2. Patient safety is included as a regular agenda item for at least the clinical and support service departments of the organization. The intent is to foster a culture of "patient safety as job number one", "Safety First". Patient safety is a high priority function in the design and redesign of processes, functions and systems that impact or involve patient care.
3. At any given time, the performance of critical steps in at least one high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance.

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4. Initiate and comply with TJC National Patient Safety Goals, and/or other regulatory or accrediting standards, by implementing the goals' elements of performance to improve Patient Safety.

Actions upon Error or Event:

Upon identification of a medical/health care error/event, the patient care provider should:

- As appropriate to the occurrence, perform healthcare interventions to contain the risk to the patient or others
- Contact the patient's attending physician and other physicians, as appropriate, to report the error or event, carrying out physician orders as necessary.
- Contact the patient's family, guardian, Power of Attorney or significant other to make aware of the error or event. Refer to the Disclosure of Treatment Outcomes policy.
- Preserve any information (Preservation Checklist) related to the error or event (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an Event Report, and in the medical record as appropriate to organizational policy and procedure.
- Report the medical/health care error to the staff member's immediate supervisor.
- Submit the Event Report to the Director of Risk Manager per the Patient Safety Evaluation System.

Individuals in any department identifying a potential patient safety issue should notify their supervisor and document the findings on an Event Report. This Patient Safety Work Product includes patient safety near misses. The Event Report should be submitted to the Director of Risk Manager.

Staff response to medical/health care occurrences is dependent upon the type of occurrence identified:

- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue should notify their supervisor and document the findings on an Event Report form. The Event Report form will be submitted to the Director of Risk Manager per organizational policy
- Serious Safety Event & Sentinel Event - staff should perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure. A root cause analysis should be performed for any sentinel event and near miss as defined in the sentinel event policy and procedure.

- Near Miss – staff should report the near miss event to their immediate supervisor, describe the facts of the near miss on an event report and submit the report to the Director of Risk Manager. A proactive risk assessment may be performed to prevent recurrence if it is determined that a recurrence poses a significant safety risk to future patients. This may be determined by the Director of Risk Manager and/or the Patient Safety Committee if there is any disagreement as to risk potential.

An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, it is the intent of this organization to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relation to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members.

Staff Support:

Staff members involved in a sentinel event occurrence will receive support from the Director of Risk Manager regarding the staff member's professional and emotional reconciliation of the sentinel event. The staff member's involvement in the root cause analysis and action plan processes is encouraged, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the hospital's social worker, psychologist or psychiatrist on staff and/or their department supervisor.

Disclosure:

Patients, and when appropriate, their families are informed regarding the unanticipated outcomes of care, or when the outcomes differ significantly from the anticipated outcomes. The Patient Safety Committee will monitor for compliance with this standard through the information management function of record reviews, and through reports from the Patient Safety Officer of evidence found upon individual record review for other risk management purposes. (See also policy regarding disclosure of unanticipated outcomes.)

Communication:

1. Medical/health care errors and occurrences, including sentinel events, will be reported to the CHS PSO, LLC and externally, per hospital policy through the channels established by this plan. External reporting will be performed in accordance with state, federal and regulatory body rules, laws and requirements (i.e., regarding medical devices in accordance with the Safe Medical Devices Act.).
2. An annual report will be compiled by the Patient Safety Committee and forwarded to the Quality Improvement Council, the Medical Executive Committee and on to the governing board. This

report shall include at least aggregate data regarding patient safety, an analysis thereof (conclusions), recommendations and actions taken to improve patient safety, both in response to actual occurrences and proactively. These reports shall be protected to the extent allowable under the disclosure laws applicable to peer review, the Quality Improvement Council, and risk management.

3. The governing board, upon evaluation of received reports (at a minimum, annually), should assess the allocation of resources, the assignment of personnel and their time, the provision of information services and data management processes, and staff training in terms of adequacy of their allocation of human, information, physical and financial resources to support patient safety improvement priorities.

Patient and Family Education:

The organization urges patients and families to get involved in their care. Educational efforts to increase consumer awareness and involvement are supported by the Centers for Medicare and Medicaid Services and TJC as a critical process to improve patient safety. The organization encourages patients and families to:

- ◆ Speak up if they have questions or concerns, and if they don't understand, ask again. Encouraging patients that it is their right to know
- ◆ Pay attention to the care received. Making sure you are getting the right treatments and medications by the right health care professionals. Don't assume anything.
- ◆ Educate yourself about diagnosis, the medical tests you are undergoing and your treatment plan.
- ◆ Ask a trusted family member or friend to be your advocate.
- ◆ Know what medications you take and why you take them. Medication errors are the most common health care mistakes.
- ◆ And to participate in all decisions about your treatment. You are the center of the health care team.

TYPE: SAFETY
TITLE: PATIENT SAFETY PLAN
ADOPTED: 8/1/2006
LAST APPROVED: 1/03/2014

SUBJECT: PATIENT SAFETY PLAN

POLICY NUMBER: 7.2

Introduction:

Safety at Elite Endoscopy encompasses:

- i. The environment of care; and
- ii. The process of care.

The environment of care is addressed in the Environmental Standards, and Safety and Infection Control Plan, while this document addresses the process of care.

Purpose:

As part of a continuous focus on the safe delivery of healthcare services, the Patient Safety Program was established as an interdisciplinary collaborative effort.

The purpose of the Patient Safety Program is to identify and effectively resolve events that result in, or have the potential to result in adverse patient care outcomes. The program is also designed to examine existing patient care processes and identify and affect improvements that reduce the risk of adverse outcomes. In achieving such, Elite Endoscopy has cultured an environment that encourages:

- i. The recognition and acknowledgement of medical/health care errors and their risks to patient safety;
- ii. The initiation of actions to reduce these risks;
- iii. The internal reporting of what has been found and the actions taken;
- iv. A focus on processes and systems;
- v. A non-punitive culture with minimization of individual blame or retribution for involvement in a medical/health care error; and

- vi. Organizational learning about medical/health care errors.

Scope of Program Activities:

The scope of the Patient Safety Program is designed to support and reflect Elite Endoscopy's commitment to fostering a culture of safety, service and continuous improvement to assure the highest-quality patient care. The Patient Safety Program is broad in its scope and includes patients, visitors, and staff. The program addresses maintenance and improvement of safety issues in the facility.

Objectives:

The objectives of the Patient Safety Program are as follows:

- i. Establish and convene an appropriate group to develop and monitor Patient Safety Program initiatives;
- ii. Develop an awareness of the Patient Safety Plan;
- iii. Develop knowledge and skills related to the analysis of patient safety events;
- iv. Prioritize and effect patient safety improvements;
- v. Determine if corrective actions and improvements are effective; and
- vi. Report to the Governing Body at least ~~annually~~ *quarterly*.

Responsibilities:

All personnel will participate in the patient safety program. All personnel are responsible for reporting patient occurrences and potential occurrences.

Patient Safety will be under the direction of the Quality Assurance Patient Safety Committee and will assist with the identification, coordination and implementation of patient safety initiatives.

Non-Punitive Reporting Culture

An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, Elite Endoscopy strives for a non-

punitive approach in its management of errors and occurrences. Personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. Elite Endoscopy supports the concept that errors occur due to a breakdown in systems and processes, and focuses on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus is placed on remedial actions to assist, rather than punish, staff members. Any identified instances of incompetence, negligence, and malfeasance that are discovered and ascertained during the evaluation of errors and occurrences are forwarded to Medical Director.

Methodology:

Identification of Medical/ Health Care Errors:

The identification of medical/health care errors includes, but is not limited, to the following mechanisms:

- Incident reporting (which includes adverse drug reactions and emergency patient transfer), and
- Sentinel Event Reporting

Options for reporting patient events are continuously being explored and will be included as they are approved.

Response to medical/health care errors

Upon identification of a medical/health care error, the staff immediately:

- i. Performs emergency healthcare interventions (if necessary) to treat the patient's clinical condition. As appropriate to the occurrence, necessary healthcare interventions are performed to contain the risk to others.
- ii. Contacts the patient's providing physician and/or other physicians, as appropriate, to report the error and carryout any physician orders as necessary.
- iii. Reports the medical/health care error to the Director of Nursing and preserves any information related to the error (including physical information). Preservation

of information includes documenting facts regarding the error on an occurrence report and in the medical record as appropriate.

- iv. Submits the report of occurrence to the Quality Assurance Committee for review under Risk Management.
- v. Patients and, when appropriate, their families are informed about the outcomes of care, this includes unanticipated adverse outcomes- a result that differs significantly, and adversely, from what was anticipated from a treatment or procedure.

Classification of Medical/Health Care Errors

Elite Endoscopy defines medical/health care error as an unintended event during the process of care. Nevada Digestive classifies unintended events during the process of care by "clinical significance" which correlates with injury severity and ranges from none to catastrophic. This classification process assists the organization in determining the types of analysis that may be applied to the event. For example, a Root Cause Analysis is always completed for those errors classified as Sentinel Events.

1. Events of No Clinical Significance –there is no evidence of injury to the patient.
2. Events of Minor Clinical Significance – these events result in only first aid care (no additional procedures, tests, medications, or increased length of stay or increased level of care).
3. Events of Moderate Clinical Significance - these events result in additional procedures, tests, or medications, or transfer to a hospital.
4. Events of Major Clinical Significance - these events result in, surgical intervention, and transfer to a hospital.
5. Events of Catastrophic Clinical Significance (Sentinel Event) - An event involving death or serious physical or psychological injury, or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:
 - i. An event that has resulted in an unanticipated death or major, permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
 - ii. An infant abduction or discharge to the incorrect family.

- iii. The rape of a patient.
- iv. A hemolytic transfusion reaction.
- v. Surgery on the wrong patient or body part; and the suicide of a patient (where the patient received "around the clock" care.

The type of analysis will be determined after evaluation of the event by the Quality Assurance Committee.

Prioritization of Safety Improvement Activities:

In a continuing effort to prevent errors and improve patient safety, Elite Endoscopy's Patient Safety Program utilizes internal and external informational resources, to identify potential improvements in patient safety. Patient complaints, occurrence reporting, State and Federal recommendations, and current literature including the National Quality Forum (NQF) compilation of Best Patient Safety Practices.

Patient Education and Patient Responsibilities:

Staff educates patients and their families about their respective roles in helping to facilitate the safe delivery of care. Patients are given information of their rights and responsibilities upon admission

Staff Education:

Staff receives education and training during their initial orientation process and on a continuing basis. The education includes, but is not limited to; the need and process of reporting medical/health care errors, and the identification and disclosure of potential risks of healthcare errors

Patient Safety Assessment:

The Patient Safety Program includes at a minimum, an annual assessment of patients, their families, and staff (including medical staff) opinions, needs and perceptions of risks to patients, and request suggestions for improving patient safety.

Governing Body

The Governing Body is responsible and accountable for the approval of the Patient Safety Plan and the oversight of the Patient Safety Program. The Governing Body

supports the appropriation of the resources necessary to address identified patient safety issues. Elite Endoscopy's progress with Patient Safety initiatives is evaluated monthly and actions are planned based on the conclusions and recommendations forwarded to it by the Quality Assurance Committee.

Quality Assurance Committee/Patient Safety Committee

The Quality Assurance Committee/Patient Safety Committee is charged with developing and monitoring the Patient Safety Program. The Quality Assurance Committee is knowledgeable of ongoing safety activities, and promotes new initiatives when necessary. Under the Patient Safety Program, the Quality Assurance Committee/Patient Safety Committee is responsible for:

- Enhancing Elite Endoscopy's commitment to patient safety
- Facilitating and coordinating patient safety activities.

POLICIES AND PROCEDURES

SECTION: N-140

DATE: 07/03

REVIEWED: 09/2018

TITLE: SAFETY RULES AND REGULATIONS (GENERAL)

POLICY: IT IS THE POLICY OF ALTA ROSE SURGERY CENTER TO PROVIDE A SAFE, HEALTHFUL, AND SANITARY WORKING ENVIRONMENT FOR PATIENTS, STAFF, AND VISITORS. STANDARDS SHALL BE SET AND MAINTAINED ACCORDING TO LOCAL, STATE AND FEDERAL RULES, LAWS, AND REGULATIONS. IT IS ONE OF THE OBJECTIVES OF THE CENTER TO COMPLY WITH ALL RULES, MANDATES, LAWS, AND REGULATIONS PERTAINING TO THE SAFETY AND HEALTH OF ITS EMPLOYEES.

PROCEDURE: EACH DEPARTMENT MANAGER IS RESPONSIBLE FOR DEVELOPING SPECIFIC WRITTEN SAFETY RULES AND REGULATIONS. THESE RULES AND REGULATIONS MUST BE A PART OF THE INTRODUCTION AND ORIENTATION OF EACH NEW EMPLOYEE BROUGHT INTO THE DEPARTMENT. SAFETY SYSTEMS WILL BE DEVELOPED AND MAINTAINED THROUGH POLICIES AND PROCEDURES TO MINIMIZE HAZARDS TO PATIENTS, STAFF, AND VISITORS. GUIDELINES FOR ALL EMPLOYEES INCLUDE THE FOLLOWING:

- 1) KNOW THE SAFETY RULES AND REGULATIONS FOR BOTH DEPARTMENT AND THOSE APPLICABLE TO THE OPERATION OF THE CENTER.
- 2) KNOW THE LOCATION AND OPERATION OF THE CENTER'S TELEPHONES, FIRE EXTINGUISHERS, EXITS, AND YOUR INDIVIDUAL RESPONSIBILITIES IN CASE OF FIRE, BOMB THREAT, OR DISASTER.
- 3) REPORT IMMEDIATELY TO YOUR SUPERVISOR HAZARDS OR VIOLATIONS OF SAFETY STANDARDS, SUCH AS IN THE FOLLOWING EXAMPLES:
 - A) DEFECTIVE EQUIPMENT;
 - B) CARELESS USE OF EQUIPMENT;
 - C) OBSTRUCTION TO EXIT DOORS, CORRIDORS, ENTRY WAYS OR ENTRY DOORS TO PATIENT ROOMS, OFFICES, OR DEPARTMENTS;
 - D) SMOKING IN UNAUTHORIZED AREAS;
 - E) WET OR SLIPPERY FLOORS;
 - F) COMBUSTIBLE MATERIALS NEAR HEAT OR OPEN FLAMES.
- 4) OBSERVE SAFETY STANDARDS IN THE USE OF WHEELCHAIRS, STRETCHERS, BEDS, OR OTHER EQUIPMENT RELATED TO PATIENT CARE.
- 5) OBSERVE THE BASIC RULES FOR LIFTING PATIENTS. PROPER BODY MECHANICS SHOULD BE USED WHEN LIFTING OR MOVING PATIENTS. REQUEST ASSISTANCE AS NECESSARY.
- 6) USE CARE WHEN APPROACHING SWINGING DOORS, CONGESTED AREAS, OR TURNING CORNERS. "NEVER RUN".
- 7) REPORT UNAUTHORIZED INDIVIDUALS NEAR OR IN THE FACILITY
- 8) DO NOT OPERATE EQUIPMENT UNLESS YOU HAVE BEEN PROPERLY INSTRUCTED.
- 9) UNPROFESSIONAL CONDUCT WILL NOT BE ALLOWED
- 10) FOLLOW SAFETY PRECAUTIONS IN DISPOSING OF ALL TYPES OF NEEDLES OR OTHER SHARP ITEMS IN THE APPROPRIATE SHARPS PUNCTURE RESISTANT CONTAINERS.
- 11) INJURY RELATED ACCIDENTS ARE TO BE REPORTED IMMEDIATELY TO YOUR SUPERVISOR.
- 12) OPERATE TOOLS AND EQUIPMENT ONLY AFTER INSTRUCTIONS AND PROPER DEMONSTRATION OF PROFICIENCY.

- 13) USE PROTECTIVE CLOTHING/EQUIPMENT WHERE INDICATED, I.E., GOWNS, MASKS, GLOVES, EYE SHIELDS, ETC.
- 14) CLEAN SPILLS IMMEDIATELY.
- 15) DISPOSE OF SHARP OBJECTS, CONTAMINATED TRASH, OR HAZARDOUS MATERIALS IN THE PROPER CONTAINERS.
- 16) FOLLOW PROTOCOL FOR HANDWASHING.
- 17) NEVER OPERATE OR USE ELECTRICAL EQUIPMENT THAT IS NOT PROPERLY GROUNDED, HAS FRAYED CORDS, OR IS MALFUNCTIONING IN ANY WAY.
- 18) MALFUNCTIONING OR BROKEN EQUIPMENT SHOULD BE IMMEDIATELY REMOVED FROM USE, APPROPRIATELY LABELED, REPORTED TO THE SUPERVISOR, AND SUBMITTED FOR REPAIR.



CARSON VALLEY MEDICAL CENTER	Section/number	Revision Date:
Department: Quality	QA 2.004	Revision Date:
Assurance and Risk Management		6/22/09 7/17/09 3/4/11 7/12/11 12/9/11 5/21/12, 2/27/15, 2/26/16, 02/28/17, 3/29/18
	New Date:	Reviewed Date: 8/27/10
Title: Patient Safety Program	8/13/08	Pages 1 of 11 pages

PURPOSE:

The purpose of the organizational Patient Safety Program at Carson Valley Medical Center is to improve patient safety and reduce risk to patients through an environment that encourages:

- A Patient Centered approach to care
- Integration of safety priorities into all relevant organization processes, functions and services
- Recognition and acknowledgment of risks to patient safety and medical/health care errors
- The initiation of actions to reduce these risks
- The internal reporting of what has been found and the actions taken
- A focus on processes and systems, and the reduction of process and system failures.
- Minimization of individual blame or retribution for involvement in a medical/health care error
- Organizational learning about medical/health care errors
- Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations

The Patient Safety Program provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

As we work toward Patient Centered Care, and therefore the maintenance and improvement of patient safety, it is a coordinated and collaborative effort. The approach to optimal patient safety involves all departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Carson Valley Medical Center. The Patient Safety Program is developed by an interdisciplinary Patient Safety Committee and approved by the Governing Body and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PROGRAM:

Scope of Activities:

The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety. Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Patient Safety Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:

- No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
- Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error resulting in an adverse event
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

Sentinel Event –NRS 439.830

"An unexpected occurrence involving facility acquired infection, death or serious physical or psychological injury or the risk thereof, including without limitation, any process variation from which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function."

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one (1) of the following (even if the outcome was not death or major permanent loss of function):

Reporting Requirements NRS 439.835 Appendix A:

1. Surgical or Invasive Procedure Events

- A. Surgery or other invasive procedure performed on the wrong site
- B. Surgery or other invasive procedure performed on the wrong patient
- C. Wrong surgical or other invasive procedure performed on a patient
- D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure

- E. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient
- 2. Product or Device Events
 - A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
 - B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
 - C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
- 3. Patient Protection Events
 - A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
 - B. Patient death or serious injury associated with patient elopement (disappearance)
 - C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting
- 4. Care Management Events
 - A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
 - B. Patient death or serious injury associated with unsafe administration of blood products
 - C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
 - D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
 - E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
 - F. Any Stage 3, Stage 4, or unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
 - G. Artificial insemination with the wrong donor sperm or wrong egg
 - H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
 - I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
- 5. Environmental Events
 - A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
 - B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
 - C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
 - D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
- 6. Radiologic Events

- A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

7. Potential Criminal Events

- A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
 - B. Abduction of a patient/resident of any age
 - C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
 - D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting
- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:

- Ethics, Rights and Responsibilities
- Provision of Care, Treatment and Services
- Medication Management
- Surveillance, Prevention and Control of Infection
- Improving Organization Performance
- Leadership
- Management of the Environment of Care
- Management of Human Resources
- Management of Information

Methodology:

The Patient Safety Committee is responsible for the oversight of the Patient Safety Program. The Director of Operations will have administrative responsibility for the program.

NRS 439.875: A Patient Safety Committee established pursuant to subsection 1 must be composed of:

- (1) The Infection Control Officer of the medical facility.
- (2) The patient safety officer of the medical facility.

- (3) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.
- (4) One member of the executive or governing body of the medical facility.

The Patient Safety Committee shall meet at least once each month.

The Patient Safety Committee shall:

- (a) Receive reports from the patient safety officer pursuant to **NRS 439.870**.
- (b) Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
- (c) Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.
- (d) Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections at the medical facility.
- (e) Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- (f) At least once each calendar quarter, report to the executive or governing body of the medical facility regarding:
 - 1) The number of sentinel events that occurred at the medical facility during the preceding calendar quarter; and
 - 2) The number and severity of infections that occurred at the medical facility during the preceding calendar quarter
 - 3) Any recommendations to reduce the number and severity of sentinel events that occur at the medical facility.
- (g) Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

The Patient Safety Officer duties include:

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

All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Patient Safety Officer and complete an occurrence report. The Patient Safety Officer in conjunction with Risk will aggregate occurrence information and present a report to the Patient Safety Committee on at least a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Patient Safety Committee will analyze the report information and determine further patient safety activities as appropriate.

- Through review of internal data reports and reports from external sources (including, but not limited to Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the Risk Performance Improvement report, the Patient Safety Committee will review Patient Safety occurrences. The Quality Manager, Patient Safety Officer, or Department Leader will:
 - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
 - Test and implement the redesigned process
 - Identify and implement measures of the effectiveness of the redesigned process
 - Implement a strategy for maintaining the effectiveness of the redesigned process over time
 - Keep the Quality Manager informed regarding any process improvements.

The following include description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organization wide program.

Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:

Perform necessary healthcare interventions to protect and support the patient's clinical condition.

- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's family/caregivers to report the incident as directed by the Quality or department leader if necessary. Contact the attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary. Document that this has been done in the medical record.

- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the occurrence report to the Risk Management Department per organizational policy.

Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Risk Management Department per organizational policy.

Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:

- No Harm Failures or Errors - (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Risk Management Department and notify their immediate supervisor.
- Mild-Moderate Adverse Outcome Failures or Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Risk Management Department per organizational policy.
 - Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will complete an occurrence report.
- Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report, submitting the report to the Risk Management Department per organizational policy. Staff will also notify the Pharmacy Department.
- Transfusion Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the

patient, carrying out any necessary physician orders. Staff will then follow the Suspected Transfusion Reaction Nursing Worksheet Policy and Procedure BB-35.

- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Risk Management Department and Patient Safety Officer per organizational policy.
- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. The staff will also notify the patient's family/caregiver to notify them of the incident and will document all notifications and interventions in the medical record. Staff will then follow the organizational Sentinel Event Policy and Procedure. The Patient Safety Officer will organize a Root Cause Analysis (RCA) as soon as possible after the event.
- Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to the Risk Management Department.

Established organizational policy (such as the Sentinel Event Policy) and/or the Patient Safety Committee and the Environment of Care Committee will determine the organizational response to process/system failures and/or medical/health care errors and occurrences. All sentinel events and other occurrences as deemed appropriate will have a root cause analysis conducted. The determination of the Patient Safety Committee and the Quality Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:

- Further remedial action activities necessary for identified occurrences
- Proactive occurrence reduction activities
- Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities
- An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences. ***See reporting of occurrences and sentinel events policy #2.025***
- All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members using the Just Culture method, with the Patient Safety Committee and the

Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.

- Sentinel Events – Quality Assurance and Risk Management encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Human Resources Department and/or his or her department supervisor (Refer to the Critical Incident Stress policy).
- The Patient Safety Program includes implementation of the recommendations set forth by the Joint Commission, or identified alternative recommendations defined by this institution, to achieve compliance with the Joint Commission established National Patient Safety Goals. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified National Patient Safety Goals.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. ***See Managing the Disclosure of Unanticipated Outcomes policy # 2.049.***
- Observation will be used ensure compliance with patient safety checklists and will offer opportunities for corrective feedback. This approach is a learning opportunity not intended for disciplinary purposes. ***See Active Surveillance of Patient Safety Checklist Use policy # 2.030.***
- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.
- A quarterly patient safety report will be forwarded to the Governing Body on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.

AB 280: CVMC has adopted the use of the following Patient Safety Checklists;

A. Patient Safety checklists included in the medical record;

1. Non-OR Invasive Procedure checklist,
2. Central Line Procedural checklist,
3. Inter-facility Transfer checklist,

4. Neurological checklist,
5. Sitter Observation checklist,
6. Initial ventilator setting checklist,
7. Medication Reconciliation form,
8. Discharge Instruction Sheet,
9. Surgical checklist

B. Patient safety checklists **Not** included in the medical record include;

1. Hand off tool,
2. Hand Hygiene Observation,
3. Multidisciplinary rounding checklist
4. Quality Assurance device tracking
5. Environment of Care/Infection Control Checklist
6. Infection Control Weekly Construction Site Observation checklist
7. CDC Environmental Checklist for Monitoring Terminal Cleaning
8. Ventilator bundle checklist,
10. Surgical site verification checklist

Please refer to the Infection Control Program policy # 101.12 for more information

Subject: **VIII - Patient Safety Plan**
Policy #: **7.6.17**

I. PURPOSE:

The purpose of the Patient Safety Plan is to outline the process for implementing a patient safety program at **Riverside Regional Medical Center Peninsula Surgery Western Nevada Surgical Center (WNSC)**- that supports the proactive reduction of medical / health care errors as well as an effective response to actual occurrences.

II. POLICY:

It is the policy of **Riverside Regional Medical Center Peninsula Surgery Western Nevada Surgical Center** to promote the reduction of risks to patients through an integrated and coordinated organization-wide approach. The **Board of Directors - Governing Body** is committed to providing the resources, delegating responsibility, and acting on reports to provide a systematic program designed to effectively reduce errors and other factors that lead to unanticipated adverse patient outcomes.

Administration shall provide an environment in which patients, their families, facility staff, managers and physicians are encouraged to identify, report and manage both actual and potential risks to patient safety. The program shall be non-punitive in nature, focusing on processes, procedures and systems rather than individuals.

III. SCOPE:

~~This policy applies to all **Riverside Health System** facilities and components. (However, internal structural variations within individual facilities may necessitate changes in review and reporting mechanisms)~~ The objectives include:

- A. To recognize risks to patient safety and sources of medical/health care errors and to initiate actions to proactively reduce these risks;
- B. To encourage learning about errors and share this knowledge to improve patient safety ;
- C. To encourage internal reporting of errors and issues;
- D. To focus on the improvement of processes and systems associated with medical/health care errors; and
- E. To minimize individual blame or retribution for involvement in a medical / health care error.
- F. To review and implement the Patient Safety goals ~~as promulgated by JCAHO~~
 - Improve the accuracy of patient identification
 - Improve the effectiveness of communication among caregivers

Date of Origin:
Authorized By:
Source:
Last Date of Review
Last Revision Date:
Units Primarily Affected:

Subject: ~~VIII - Patient Safety Plan~~

Policy #: ~~7.6.17~~

- Improve the safety of using high-alert medications
- Eliminate wrong-site, wrong-patient and wrong-procedure surgery
- ~~Improve the safety of infusion pumps~~
- Improve the effectiveness of clinical alarm systems

IV. AUTHORITY & RESPONSIBILITY:

- A. ~~Board of Directors – The Board of Directors of Riverside Regional Medical Center~~ Peninsula Surgery Centers, L.L.C. Governing Body – The Governing Body of WNSC has the ultimate responsibility for patient safety. To fulfill the commitment to patient safety, the board delegates

18

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the responsibility for identifying, analyzing and managing patient safety activities to administration, management, supervisors, medical staff and employees. The ~~Board Governing Body~~ recognizes that proactive management of patient safety is a continuous, ongoing process; therefore they will provide the necessary resources to carry out this philosophy. Through the development of strategic initiatives, the ~~Board Governing Body~~ provides direction for the organization's improvement activities. ~~Monthly~~ Reports from the ~~Quality Council~~ Utilization Review/Quality Improvement Committee provide the Board with a means of evaluating the organization's effectiveness in reducing risks to patient safety. ~~The Board reviews and evaluates the Quality Council's annual report, which addresses the prior year's patient safety program activities and uses the information for developing the next year's initiatives.~~

- B. Administration and Managers – Administration and managers are responsible for supporting the Patient Safety Plan and the risk reduction efforts of the organization. These efforts are given a high priority, especially when processes are designed or redesigned. To support these activities the organization will provide:
- Adequate resources;
 - Staff to participate in risk reduction activities;
 - Adequate time for staff to participate;
 - Adequate information systems and data management systems; and
 - Staff education regarding risk reduction strategies.
- C. Medical Staff -The Medical Staff is involved in patient safety activities by participation in ~~various Medical Staff and Medical Center committees including, but not limited to, the Quality Council, Clinical Review/Performance Improvement Committees, Pharmacy and Therapeutics Committee and the Infection Control Committee.~~ They provide support and oversight for organization wide performance improvement and patient safety activities by assisting with the identification of priorities for improvement, assuring physician input, developing action plans as appropriate, and communicating all relevant

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Subject: **VIII - Patient Safety Plan**
Policy #: **7.6.17**

~~information to the full Medical staff. Reports from the various Medical Staff committees are submitted to the Medical Executive Committee and the Quality Council/the Utilization/Quality Improvement Committee, on a regular basis.~~

~~D. Committees~~

~~1. Quality Council The Quality Council oversees, coordinates, and directs the performance improvement activities at ~~Riverside Regional Medical Center~~ Peninsula Surgery Center, including activities involved in the identification, analysis and improvement of risks to patient safety. The Quality Council delegates to the Medical Staff and ~~Riverside Regional Medical Center~~ departments, respective standing committees and other ad hoc committees, the authority to provide effective mechanisms to monitor and evaluate the quality and appropriateness of patient care outcomes.~~

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~~Regarding patient safety, the Quality Council is responsible for coordinating activities that will result in the reduction of medical/health care errors. This is accomplished through a proactive risk assessment process and through the use of available information regarding sentinel events and other medical/health care errors known to occur in other organizations.~~

~~a. Proactive Risk Assessment~~

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- ~~1) At least one high risk process will be identified by the Quality Council annually to undergo a proactive risk assessment. The process to be selected will be based on information identified through literature review and/or information published by JCAHO in *Sentinel Event Alerts* identifying the most frequently occurring sentinel events.~~
- ~~2) The process is assessed to identify steps that may cause undesirable variations.~~
- ~~3) For each identified variation, the possible effects, including the seriousness of the effects, on the patient are identified.~~
- ~~4) For the effects on the patient that are determined to be critical, a root cause analysis is conducted to determine why the effect may occur.~~
- ~~5) The process will then be redesigned to reduce the risk of these variations occurring or to protect the patient from the effects.~~
- ~~6) The redesigned process will be tested and then implemented. Performance measures will be developed and implemented to measure the effectiveness of the new process.~~
- ~~7) Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.~~

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~~b. Literature Based Information~~

- ~~1) Information contained in *Sentinel Event Alerts* (Patient Safety Goals) and/or obtained from other sources will be forwarded by the Performance Improvement Department to the Quality~~

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Subject: ~~VIII - Patient Safety Plan~~
Policy #: ~~7.6.17~~

~~Council, department managers, other appropriate committees or individuals for their review and consideration.~~

- ~~2)The Council will recommend actions to be taken and will delegate the actions to existing committees, the appropriate department or process owners, or will sanction the formation of a Quality Improvement team.~~
- ~~3)Outcomes related to these actions will be reported to the Quality Council and are documented in the Council's minutes.~~

~~2.Root Cause Analysis Committee The Root Cause Analysis Committee addresses Sentinel Events and near misses (see definitions below and Sentinel Event Policy #704.00). Risk reduction activities are identified, interventions implemented and reviews are conducted to assess the effectiveness of the interventions. Reports are submitted to the Quality Council on a regular basis.~~

~~3.Safety Committee The Safety Committee provides the mechanism to monitor and evaluate patient safety related to environmental issues. These issues could include but are not limited to:~~

- ~~a.Patient Falls;~~
 - ~~b.Medical Equipment (SMDA); and~~
 - ~~c.Hazardous conditions (Defined as any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of a serious adverse outcome.);~~
- ~~Reports are submitted to the Quality Council on a regular basis at least quarterly.~~

~~E. Employees and Volunteers The role of the individual employee and volunteer is critical to the success of a patient safety initiative. Patient safety is everyone's responsibility. All employees and volunteers must believe that every patient care process can be improved and feel empowered to fix and prevent problems, as well as contribute to improvement efforts. Any employee, medical staff member or volunteer may make a suggestion for a patient safety initiative through their department manager or the Quality Choice program supervisor.~~

~~Refer to the Performance Improvement Policy for further delineation of the integration of patient safety with Performance Improvement.~~

V. MEDICAL/HEALTH CARE ERROR AND NEAR MISS REPORTING

A. Definitions:

- Error – an unintended act, either of omission or commission, or an act that does not achieve its intended outcome.
- Near Miss - used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a ~~serious adverse outcome~~

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Subject: VIII - Patient Safety Plan

Policy #: 7.6.17

- ~~Sentinel Event—an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.~~
- B. In response to a medical/health care error, appropriate steps will be taken in the care of the patient to minimize negative outcomes. Any appropriate steps that would decrease the possibility of the error occurring again, or that would protect others from the risk, will be implemented immediately.
- C. The physician or his/her designee will clearly explain the outcome of any treatments or procedures to the patient and/or family members as soon after the incident as is possible and appropriate whenever those outcomes differ significantly from the anticipated outcomes.
- D. When a medical/health care error occurs that has caused harm to a patient, staff members will immediately notify the ~~manager of the department~~ Administrator. The ~~manager~~ Administrator is then responsible for ~~investigating the incident and notifying the appropriate organizational leaders including the risk manager and administration.~~

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~~E. When a medical/health care error or near miss occurs, a staff member involved in~~

~~F. in the occurrence will complete an Incident Report and Follow-Up. the occurrence will complete a Quality Care Control Report (QCCR) as described in the Medical Center’s policy: Incident Report and Follow-up (#604.00).~~

~~F. The manager Nurse of the department where the error or near miss occurred will begin the preliminary analysis. All information obtained during the analysis will be reported to Risk Management and/or the appropriate committee the Administrator.~~

~~the preliminary analysis. All information obtained during the analysis will be reported to the Administrator.~~

~~G.G. Care will be taken at the time that an error or near miss occurs to preserve any information or evidence that may be helpful in the analysis of the error- information or evidence that may be helpful in the analysis of the error.~~

~~H. The QCCR will be forwarded to the Risk Management Department for review. Depending on the type of medical /health care error, the issue will be forwarded to Administration for assignment to the appropriate committee for further review and action planning.~~

~~L. Depending on the nature and severity of the medical/health care error, the appropriate external authorities (such as the Food and Drug Administration (FDA), National Institute Occupational Safety Administration (NIOSA), United States Pharmacopeia (USP), Nevada Department of Health) will be notified of the~~

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Peninsula Surgery Centers, L.L.C. Western Nevada Surgical Center

Category: FIRE SAFETY AND DISASTER PLANNING Safety

Page 6 of 36

Subject: VIII - Patient Safety Plan

Policy #: 7.6.17

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error. The Administrator will discuss the details of each case with appropriate staff to determine what authorities need to be notified.

I. ~~appropriate external authorities (such as the Food and Drug Administration (FDA), National Institute Occupational Safety Administration (NIOSA), United States Pharmacopeia (USP), Virginia Department Mental Health/Mental Retardation Services and the Virginia Nevada Department of Health) will be notified of the error. The Risk Manager Administrator will discuss the details of each case with appropriate administrators staff to determine what authorities need to be notified.~~

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J. ~~When a medical/health care error is determined to fall within the definition of a sentinel event as defined in the "Sentinel Event" policy, then a root cause analysis will be completed within 45 days of the determination as a Sentinel Event.~~

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K. ~~Staff involved in a serious medical/health care error or sentinel event may need additional support. As appropriate, the department manager will facilitate contacting the Employee Assistance Program (EAP).~~

Data related to medical/health care errors, near misses and sentinel events will be aggregated, analyzed across the

organization to identify patterns and trends and appropriate action implemented.

VI. NEW AND REVISED PROCESSES

Patient safety is given high priority at ~~Riverside Regional Medical Center~~ Peninsula Surgery at Western Nevada Surgical Center. Patient safety considerations must be an integral part of the development of new policies, procedures, systems and services. When existing policies, procedures, systems and services are revised and re-evaluated, patient safety considerations will be addressed.

VII. STAFF EDUCATION

Patient safety will be included in the orientation program for all new employees, both at the facility level and the department specific level. Annual review and updated information will be presented as part of the mandatory annual safety training.

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Peninsula Surgery Centers, L.L.C. Western
Nevada Surgical Center

Category: FIRE SAFETY AND DISASTER PLANNING Safety

Subject: VIII - Patient Safety Plan

Policy #: 7.6.17

Page 7 of 36

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~~20~~On-going education regarding *Sentinel Event Alerts* will be provided as appropriate to the facility, department and job class. Department managers may provide specific education annually as appropriate for their specific needs.

Attachment A

Carson Tahoe Regional Medical Center 2019 Checklist Inventory			
Checklist Title		Checklist Category	Department
1	HERT Team Leader Checklist	Other Safety	Emergency Mgt.
2	HERT Activation Checklist	Other Safety	Emergency Mgt.
3	HERT Ambulatory and Non-Ambulatory Set-Up Checklist	Other Safety	Emergency Mgt.
4	HERT Dirty Water Set-up Checklist	Other Safety	Emergency Mgt.
5	HERT Triage/Morgue Set-up Checklist	Other Safety	Emergency Mgt.
6	HERT Tent Set-up Checklist	Other Safety	Emergency Mgt.
7	HERT Receiving Checklist	Other Safety	Emergency Mgt.
8	217 Telemetry, Medical/Oncology & Pharmacy Swing	Environment	Housekeeping
9	304 Projects/Floor Care	Environment	Housekeeping
10	Form 100 Lead/Admin	Environment	Housekeeping
11	Form 101 Telemetry	Environment	Housekeeping
12	Form 102 Medical Oncology A & Pharmacy	Environment	Housekeeping
13	Form 103 Medical Oncology B Therapy Gym	Environment	Housekeeping
14	Form 104 OB/Peds	Environment	Housekeeping
15	Form 105 Surgical/Orthopedics	Environment	Housekeeping
16	Form 106 ICU/CVU	Environment	Housekeeping
17	Form 107 ER/OBS/Fast Track Days	Environment	Housekeeping
18	Form 108 OR Days	Environment	Housekeeping
19	Form 109 Cath Lab/Outpatient Days	Environment	Housekeeping
20	Form 110 Public Area	Environment	Housekeeping
21	Form 111 Waste Management Days	Environment	Housekeeping
22	Form 112 BHS Check Sheet	Environment	Housekeeping
23	Form 113 BHS 'C' Unit	Environment	Housekeeping
24	Form 114 Floor Care	Environment	Housekeeping
25	Form 200 Lead	Environment	Housekeeping
26	Form 202 Tele/OB Swing	Environment	Housekeeping
27	Form 203 Swing Surgical/Orthopedics, CVU and ICU	Environment	Housekeeping
28	Form 204 ICU/CVU Swing	Environment	Housekeeping
29	Form 205 ER/OBS Fast Track Swing	Environment	Housekeeping
30	Form 206 OR Swing	Environment	Housekeeping
31	Form 207 Cath Lab/X-Ray Outpatient	Environment	Housekeeping
32	Form 208 Waste Management Swing	Environment	Housekeeping
33	Form 209 SMC First Floor	Environment	Housekeeping
34	Form 210 Cancer/Merriner	Environment	Housekeeping
35	Form 211 Minden Checklist	Environment	Housekeeping
36	Form 212 Mica Surgery/Pain Clinic	Environment	Housekeeping
37	Form 213 Projects/Floor Care	Environment	Housekeeping
38	Form 214 Projects/Floor Care	Environment	Housekeeping
39	Form 215 Projects/Floor Care	Environment	Housekeeping
40	Form 216 Lab/Office Swing	Environment	Housekeeping
41	Form 217 Telemetry, Med Oncology A and Phm Swing	Environment	Housekeeping
42	Form 301 ER/OBS/Fast Track	Environment	Housekeeping

Attachment A

Carson Tahoe Regional Medical Center 2019 Checklist Inventory			
	Checklist Title	Checklist Category	Department
43	Form 302 OR	Environment	Housekeeping
44	Form 303 Basement/Discharges/OR	Environment	Housekeeping
45	Form 304 Projects/Floor Care	Environment	Housekeeping
46	Quality Assurance Checklist	Environment	Housekeeping
47	Pediatric Unit Department Checklist	Environment	PEDS
48	Discharge Checklist for Patients	Discharge	BHS
49	Discharge Checklist for Nursing	Discharge	BHS
50	Admission Checklist Nurse and Tech/Unit Clerk	Other Safety	BHS
51	AMA Intervention Checklist	Other Safety	BHS
52	Shift Checklist for Nursing Staff	Other Safety	BHS
53	Psychosocial Treatment Plan Tracking Form	Treatment	BHS
54	Sharp Contraband Tracking Form	Treatment	BHS
55	Fire Drill Participation	Environment	House wide- Security
56	Fire Report	Environment	Security
57	Fire Watch Form	Environment	Security
58	Life (Fire) Safety Inspection/Business Occupancy	Environment	Security
59	Life (Fire) Safety Inspection/Healthcare Occupancy	Environment	Security
60	Patient Observation Checklist	Other Safety	Security
61	Adult Crash Cart Checklist	Other Safety	House wide
62	Newborn Nursery Crash Cart Checklist	Other Safety	House wide
63	OB Hemorrhage Cart Checklist	Other Safety	House wide
64	Pediatric Crash Cart Checklist	Other Safety	House wide
65	OB Recovery Room Red Cart	Other Safety	House wide
66	OB OR Checklist	Other Safety	Women's/Children
67	3M Steam Flash Sterilization Log	Other Safety	House wide
68	AED Checklist	Other Safety	House wide
69	Breast Milk Refrigerator Temperature Log	Other Safety	Women's/Children
70	Refrigerator/Freezer Temperature Record	Other Safety	House wide
71	List and Process Monitor Documentation System	Other Safety	GBI
72	NV State Immunization Program Temperature Log	Other Safety	Women's/Children
73	Nursery Blanket Warmer Temperature Log	Other Safety	Women's/Children
74	OB/RR Blanket Warmer Temperature Log Top Compartment	Other Safety	House wide
75	Ticket to Ride	Other Safety	House wide
76	Central Line Associated Blood Stream Infection (CLABSI) and Catheter Associated Urinary Tract Infection (CAUTI) surveillance	Other Safety	Infection Control
77	CAUTI Bundle Audit Data Collection	Other Safety	Infection Control
78	Hand Hygiene Compliance Monitoring	Other Safety	Infection Control
79	Infection Control Risk Assessment	Other Safety	Infection Control
80	Emergency Equipment Checklist	Other Safety	ICU
81	Urgent Heart Chart Daily Checklist	Other Safety	ICU

Attachment A

Carson Tahoe Regional Medical Center 2019 Checklist Inventory			
	Checklist Title	Checklist Category	Department
82	Chemotherapy Administration Checklist	Other Safety	Medical Oncology
83	Pre-Op/Circ/PACU Chart Deficiency Checklist	Treatment	Surgical Areas
84	Hand-off Communication Sheet Pre-Op/OR/PACU	Treatment	Surgical Areas
85	Surgical Checklist	Treatment	Surgical Areas
86	Universal Protocol Checklist/Hand-off Communication	Treatment	Surgical Areas (not SSH)
87	Universal Protocol Checklist for Injection Procedures	Treatment	Surgical Areas (not SSH)
88	Pre-op/Procedural Checklist	Other Safety	Surgical Areas (not SSH)
89	Ventilator Calibration Checklist	Other Safety	Respiratory
90	BHS Unit Safety Rounds Worksheet	Other Safety	House wide
91	Carson Tahoe Emergency Department Triage Protocol	Other Safety	Emergency Dept.
92	Carson Tahoe Emergency Department Stroke Protocol (MD Guidelines)	Other Safety	Emergency Dept.
93	Magnetic Resonance Imaging (MRI) History and Assessment	Treatment	Medical Imaging
94	MRI Invasive Procedure Checklist	Treatment	Medical Imaging
95	Non-Ionic and/or Ionic Contrast Consent Form	Treatment	Medical Imaging
96	Pre-Catheterization/Vascular Lab Checklist	Treatment	Catheterization Lab
97	Patient Room Safety Inspection	Other Safety	House wide
98	Pre-op Education	Treatment	Mica Surgery

Encompass Health Rehabilitation Hospital of Desert Canyon

Policy#: 180	Title: Patient Safety Plan	Category: Plans
Policy Status: Published	Effective Date: 03/09/2018	Last Reviewed Date: 03/09/2018

PROCEDURE

PROCEDURE INSTRUCTIONS

PURPOSE:

The purpose of the Patient Safety Program is to improve patient safety and reduce risk to patients, staff and visitors. Recognizing the effective medical/health care error reduction requires an integrated and coordinated approach; we have developed an organization-wide safety program. The program supports the creation of an environment in which patients, their families, and organization staff leaders can identify and manage actual and potential risks to patient safety.

OBJECTIVE:

It is our objective to foster an environment to improve patient safety, establish mechanism to support effective responses to actual occurrences and to be proactive in the reduction of medical/health care errors. Patient safety will be a priority in new design and all relevant organization processes, functions and services.

SCOPE:

The scope of the patient safety program will include compliance with standards identified by external regulatory agencies and accrediting bodies. Program activities will address occurrences ranging from "near misses" to sentinel events with serious adverse outcomes.

DEFINITIONS:

Actual Event-an event occurred that reached the patient or individual (e.g., visitor fall, student injury, etc.).

Near Miss-an event occurred but it did not reach the patient because of chance alone or because of active recovery efforts by caregivers.

Unsafe Condition- circumstances that could cause adverse events (e.g., look-alike medications, confusing equipment, failure to use proper signage when floor is wet).

Sentinel Event- is defined as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Severe temporary harm which is defined as critical, potentially life-threatening harm lasting for a limited time with no permanent residual effect, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition. (Hip fractures are always included)
- Permanent harm
- Death

For additional events also considered "sentinel" reference the HealthSouth Sentinel Event policy

PROCEDURES:

A. The responsibility for management of the organization-wide patient safety program is assigned to the Director of Quality/Risk Management.

1. The Safety Committee and Quality Council will provide interdisciplinary input related to patient, visitor and staff safety.
2. Reports of safety related activities and issues would be presented to Department Managers, Senior Staff, Medical Staff via the Medical Executive Committee, and the Governing Board. This communication is confidential and for quality assurance purposes only.

B. Staff will report information relating the medical/health care events as outlined in Risk Management Electronic Event Reporting Policy.

1. Staff will be oriented to the Risk Management Policies on hire and through ongoing in-service and other education and training programs.
2. Staff will be oriented to their roles in preventing adverse occurrences as related to their specific job responsibilities and as a part of the organization-wide efforts to improve patient safety.
3. Staff will be oriented to the importance of reporting "near misses," as well as adverse occurrences.
4. Team training to foster an interdisciplinary, collaborative approach to patient care delivery and to reinforce the need and way(s) to report medical/health care errors will be provided as appropriate.
5. The Director of Quality/Risk Management, Department Managers, and Senior Staff are responsible for interacting with staff in a manner that ensures staff do not fear disclosure, embarrassment, blame or punishment for reporting potential or actual events related to patient safety.
6. The Director of Quality/Risk Management, Department Manager and/or Senior Staff member may request the assistance of internal behavioral management staff or external resources if a staff member(s) needs support in coping with a sentinel event.

C. Hospital leadership will identify barriers to effective communication among caregivers relative to patient care, redesign the process to eliminate barriers and monitor for effectiveness. Specific attention will be directed to:

1. Process for ensuring accurate, timely, and complete verbal and written communication among care givers and all others involved in utilization of data, and
2. Test results relative to the management of the patient's condition.

D. All patients are entitled to information about all aspects of their health care, including information about clinically relevant unanticipated outcomes of care.

Patients and, when appropriate, their families are informed about the outcomes of care including unanticipated outcomes (i.e. sentinel events, State reportable events). Responsibility for disclosing unanticipated outcomes typically rests with the physician or designee who has overall responsibility for the patient's care. However, in some situations, other healthcare professionals may be deemed more appropriate to be responsible for disclosing the outcome. A hospital representative, preferably the Quality/Risk Director, Chief Nursing Officer or the Chief Executive Officer should be present for the initial conversation and any follow-up discussions that may occur with the patient and/or patient's representative.

E. The Director of Quality/Risk Management or designee will respond immediately to notification of significant medical/health events to a patient/visitor or staff member.

1. The Nursing Supervisor or Department Manager will contact the Risk Manager and/or Administrator/Administrator-On-Call to report events.
2. Action(s) will be taken to protect the patient/visitor/staff members as indicated per hospital plans and policies.
3. Factual information will be obtained and preserved for subsequent analysis. Such information is confidential for quality assurance purposes.

F. The facility will review historical risk management, Environment of Care (EOC), Program Improvement (PI) and Human Resources (HR) data for high volume, high risk problem trends in medical and care processes, as well as unanticipated adverse occurrences affecting patients. These will be ranked as:

- A. Unsafe condition (Non-event)
- B1. Near Miss - No Harm/Didn't Reach Patient/Caught by Chance
- B2. Near Miss - No Harm/Didn't Reach Patient b/c of Active Recovery by Caregiver
- C. No Harm – Reached Patient No Monitoring Required
- D. No Harm – Reached Patient Monitoring Required
- E. Harm – Temporary, Intervention Needed
- F. Harm – Temporary, Hospitalization Needed
- G. Harm - Permanent
- H. Harm – Permanent, Intervention Required to Sustain Life
- I. Death

G. The facility will also perform intense analysis consistent with the Root Cause Analysis/Sentinel Event Policies, and reports as required by state, regulatory, and accreditation bodies. The Risk Management designee is responsible for ensuring compliance with reporting.

H. Emerging needs requiring reprioritizing performance improvement activities may be identified through data collection and assessment, unanticipated adverse occurrences affecting patients, changing regulatory requirements, significant patient and staff needs, changes in the environment of care, or changes in the community. Priority consideration in establishing performance improvement teams is given to:

1. Processes that affect a large percentage of patients.
2. Processes that place patients at risk, if not performed well, if performed when not indicated, or if not performed when indicated.

Processes that have been or are likely to be problem prone.

I. When designing/redesigning processes, Department Managers and staff will:

1. Incorporate information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesigned process, function or service.
2. Conduct literature searches to obtain evidence based medical and/or care practices to be included in process redesign.
3. Include analysis and or pilot testing to determine whether the proposed design/redesign is an improvement.

J. Hospital leadership will consider the importance of patient safety in:

1. Development of hospital-wide patient care programs, policies and procedures that describe how patients' care needs are assessed and met.
2. Development and implementation of the hospital's plan for the provision of patient care.
3. Decision-making structures and processes.
4. Implementation of an effective and continuous program to measure assesses and improves performance.
5. Development of an interdisciplinary culture that emphasizes cooperation and communication. The leadership role of coaching will be used to promote communication among services, individual staff members and less formal structures such as quality action teams, performance-improvement teams or members of standing committees.
6. Development of a process to involve the patient, as appropriate to his/her condition, as a partner in helping to facilitate the safe delivery of care.
 - a. Patients/family members are oriented on admission of the importance of reporting perceived risks and concerns about the patient's care per Patient and Customer Complaint and Grievance Policy.

b. Department Managers and Senior Staff will review Press Ganey Patient Satisfaction Survey questions related to patient safety and develop a corrective action plan to patient/family complaints or suggestions for improving safety as appropriate.

7. The Governing Board will appoint the Director of Quality and Risk Management (DQR) as the Patient Safety Officer. The Patient Safety Officer/Director's role includes:

- Participating in hazard surveillance, event reporting, reviewing, and the development of patient safety policies and procedures.
- Analyzing and seeking resolution of patient safety issues and works with the appropriate staff to implement recommendations and to monitor patient safety improvement activities.
- Report on findings, recommendations, actions taken, and results of measurements through the hospital quality structure.

K. At least one (1) high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance, a minimum of 1 proactive risk assessment every 18 months. The process selected will be based, in part, on the information identifying the most frequently occurring sentinel events and patient safety risk factors.

1. Assess the intended and actual implementation of this process to identify steps in the process where there is, or may be, undesirable variation (i.e. called potential "failure modes").
2. For each identified "failure mode," identify the possible "effect(s)" and how serious the possible effect on the patient could be (i.e. "criticality" of the effect).
3. For the most critical effects, conduct a root cause analysis to determine the variation (failure mode) leading to that effect occur.
4. Redesign the process and/or underlying systems to minimize the risk of that failure mode to protect patients from the effect of that failure mode.
5. Test and implement the redesigned process.
6. Identify and implement measures of the effectiveness of the redesigned process.
7. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

L. Hospital leadership will measure and assess the effectiveness of their contributions to improving patient safety. To accomplish these goals, leaders will.

1. Set measurable objectives for improving patient safety.
2. Actively request staff to periodically discuss their opinions, needs, perceptions of risks to patients and suggestions for improving patient safety. The actions taken as a result of this staff input will be reported to the MEC/GB bi- annually.
3. Review data on staff willingness to report medical/health events.
4. Review data from Patient Satisfaction Survey related to patient safety.
5. Use pre-established, objective process criteria to assess their effectiveness in improving patient safety.
6. Draw conclusions based on their findings and develop and implement improvement in their activities.
7. Evaluate their performance in supporting sustained improvement.

M. The DQR will report at a minimum quarterly to the Governing Board occurrences of medical/health events and actions to improve patient safety.

N. The DQR will report any sentinel event within the allotted timeframe to the Nevada Division of Public and Behavioral Health via "RedCap" along with reporting to corporate risk management.

Close

Encompass Health Rehabilitation Hospital of Desert Canyon

Policy#: 180	Title: Patient Safety Plan	Category: Plans
Policy Status: Published	Effective Date: 03/09/2018	Last Reviewed Date: 03/09/2018

PROCEDURE

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OBJECTIVE:

It is our objective to foster an environment to improve patient safety, establish mechanism to support effective responses to actual occurrences and to be proactive in the reduction of medical/health care errors. Patient safety will be a priority in new design and all relevant organization processes, functions and services.

SCOPE:

The scope of the patient safety program will include compliance with standards identified by external regulatory agencies and accrediting bodies. Program activities will address occurrences ranging from "near misses" to sentinel events with serious adverse outcomes.

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- Permanent harm
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B. Staff will report information relating the medical/health care events as outlined in Risk Management Electronic Event Reporting Policy.

1. Staff will be oriented to the Risk Management Policies on hire and through ongoing in-service and other education and training programs.
2. Staff will be oriented to their roles in preventing adverse occurrences as related to their specific job responsibilities and as a part of the organization-wide efforts to improve patient safety.
3. Staff will be oriented to the importance of reporting "near misses," as well as adverse occurrences.
4. Team training to foster an interdisciplinary, collaborative approach to patient care delivery and to reinforce the need and way(s) to report medical/health care errors will be provided as appropriate.
5. The Director of Quality/Risk Management, Department Managers, and Senior Staff are responsible for interacting with staff in a manner that ensures staff do not fear disclosure, embarrassment, blame or punishment for reporting potential or actual events related to patient safety.
6. The Director of Quality/Risk Management, Department Manager and/or Senior Staff member may request the assistance of internal behavioral management staff or external resources if a staff member(s) needs support in coping with a sentinel event.

C. Hospital leadership will identify barriers to effective communication among caregivers relative to patient care, redesign the process to eliminate barriers and monitor for effectiveness. Specific attention will be directed to:

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3. Factual information will be obtained and preserved for subsequent analysis. Such information is confidential for quality assurance purposes.

F. The facility will review historical risk management, Environment of Care (EOC), Program Improvement (PI) and Human Resources (HR) data for high volume, high risk problem trends in medical and care processes, as well as unanticipated adverse occurrences affecting patients. These will be ranked as:

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- H. Harm – Permanent, Intervention Required to Sustain Life
- I. Death

G. The facility will also perform intense analysis consistent with the Root Cause Analysis/Sentinel Event Policies, and reports as required by state, regulatory, and accreditation bodies. The Risk Management designee is responsible for ensuring compliance with reporting.

H. Emerging needs requiring reprioritizing performance improvement activities may be identified through data collection and assessment, unanticipated adverse occurrences affecting patients, changing regulatory requirements, significant patient and staff needs, changes in the environment of care, or changes in the community. Priority consideration in establishing performance improvement teams is given to:

1. Processes that affect a large percentage of patients.
2. Processes that place patients at risk, if not performed well, if performed when not indicated, or if not performed when indicated.

Processes that have been or are likely to be problem prone.

I. When designing/redesigning processes, Department Managers and staff will:

1. Incorporate information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesigned process, function or service.
2. Conduct literature searches to obtain evidence based medical and/or care practices to be included in process redesign.
3. Include analysis and or pilot testing to determine whether the proposed design/redesign is an improvement.

J. Hospital leadership will consider the importance of patient safety in:

1. Development of hospital-wide patient care programs, policies and procedures that describe how patients' care needs are assessed and met.
2. Development and implementation of the hospital's plan for the provision of patient care.
3. Decision-making structures and processes.
4. Implementation of an effective and continuous program to measure assesses and improves performance.
5. Development of an interdisciplinary culture that emphasizes cooperation and communication. The leadership role of coaching will be used to promote communication among services, individual staff members and less formal structures such as quality action teams, performance-improvement teams or members of standing committees.
6. Development of a process to involve the patient, as appropriate to his/her condition, as a partner in helping to facilitate the safe delivery of care.
 - a. Patients/family members are oriented on admission of the importance of reporting perceived risks and concerns about the patient's care per Patient and Customer Complaint and Grievance Policy.

b. Department Managers and Senior Staff will review Press Ganey Patient Satisfaction Survey questions related to patient safety and develop a corrective action plan to patient/family complaints or suggestions for improving safety as appropriate.

7. The Governing Board will appoint the Director of Quality and Risk Management (DQR) as the Patient Safety Officer. The Patient Safety Officer/Director's role includes:

- Participating in hazard surveillance, event reporting, reviewing, and the development of patient safety policies and procedures.
- Analyzing and seeking resolution of patient safety issues and works with the appropriate staff to implement recommendations and to monitor patient safety improvement activities.
- Report on findings, recommendations, actions taken, and results of measurements through the hospital quality structure.

K. At least one (1) high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance, a minimum of 1 proactive risk assessment every 18 months. The process selected will be based, in part, on the information identifying the most frequently occurring sentinel events and patient safety risk factors.

1. Assess the intended and actual implementation of this process to identify steps in the process where there is, or may be, undesirable variation (i.e. called potential "failure modes").
2. For each identified "failure mode," identify the possible "effect(s)" and how serious the possible effect on the patient could be (i.e. "criticality" of the effect).
3. For the most critical effects, conduct a root cause analysis to determine the variation (failure mode) leading to that effect occur.
4. Redesign the process and/or underlying systems to minimize the risk of that failure mode to protect patients from the effect of that failure mode.
5. Test and implement the redesigned process.
6. Identify and implement measures of the effectiveness of the redesigned process.
7. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

L. Hospital leadership will measure and assess the effectiveness of their contributions to improving patient safety. To accomplish these goals, leaders will.

1. Set measurable objectives for improving patient safety.
2. Actively request staff to periodically discuss their opinions, needs, perceptions of risks to patients and suggestions for improving patient safety. The actions taken as a result of this staff input will be reported to the MEC/GB bi- annually.
3. Review data on staff willingness to report medical/health events.
4. Review data from Patient Satisfaction Survey related to patient safety.
5. Use pre-established, objective process criteria to assess their effectiveness in improving patient safety.
6. Draw conclusions based on their findings and develop and implement improvement in their activities.
7. Evaluate their performance in supporting sustained improvement.

M. The DQR will report at a minimum quarterly to the Governing Board occurrences of medical/health events and actions to improve patient safety.

N. The DQR will report any sentinel event within the allotted timeframe to the Nevada Division of Public and Behavioral Health via "RedCap" along with reporting to corporate risk management.

Close

**Dignity Health – St. Rose Dominican
San Martin Campus
PATIENT SAFETY/RISK MANAGEMENT PLAN**

DATE: 01/2019



This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Patient Safety Committee/Program
St. Rose Dominican – San Martin Campus
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Contents

Commitment to Patient Safety.....	3
Mission, Vision, and Values	3
Scope and Purpose.....	3
Roles and Responsibilities	4
Roles and Responsibilities	4
Objectives and Goals of the Patient Safety/Risk Management Plan	10
Components and Methods	11
Root Cause Analysis	14
Model for Improvement	15
Data Collection and Reporting.....	15
Ongoing Reporting and Review.....	15
Assessment of the Quality and Patient Safety Plan	16
Patient Safety Checklists and Patient Safety Policies	16
Approval of Patient Safety Plan.....	17
References	18

Commitment to Patient Safety

Dignity Health St. Rose Dominican Hospital – San Martin Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe 2018 for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Dignity Health – St. Rose Dominican, San Martin Campus' Patient Safety/Risk Management program promotes:

- Honest, open collaboration and partnership of hospital leadership, medical staff, patients and their families, the community and other healthcare providers to deliver compassionate, high-quality, affordable healthcare.
- Promote justice and respect for those we serve.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility and accountability for every healthcare related decision and action.
- A focus on excellence, teamwork and innovation through continuous learning, improvement in system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The Patient Safety/Risk Management Program at St. Rose Dominican is an organization-wide/campus specific strategy that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety/Risk Management Program at San Martin Campus supports and encourages the active participation of each person in order to be an effective program. When processes, functions or services are designed or redesigned, information internal and external to the campus and/or organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or services.

The purpose of this plan is to establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program Plan designed to promote and improve patient safety at Dignity Health – St. Rose Dominican, San Martin Campus, by working to prevent medical/healthcare adverse events and reducing risk to patients and visitors.

Undesirable facility specific and system patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns or trends vary significantly and undesirably from those expected including significant near misses;
- Performance varies significantly and undesirable from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
 - Hospital acquired infections
 - Medication events, to include delays in administration
 - Adverse drug events
 - Transfusion reactions
 - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

Roles and Responsibilities

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

The Patient Safety Committee Organization

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;

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

The roles and responsibilities are defined below.

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

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the San Martin Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.

- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- See Quality Department's Performance Improvement Plan

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

The Manager of Risk Services has been designated the Patient Safety Officer for the San Martin Campus and as such, has the administrative responsibility for the program specific responsibilities including:

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Day to day responsibility for the Patient Safety/Risk Management Program at San Martin Campus.
- Maintenance of related data collected, trended and analyzed at each campus.
- Routine reporting to leadership and QCAC on campus specific trended data and actions taken to improve the quality and safety of patient care.
- Working with QCAC to achieve the goals of the Patient Safety/Risk Management Program.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.

- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporates the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Identify RCA participants and coordinate a time, date and location of RCA meeting.
- Inform RCA participants of the sentinel event process.
- Explain confidential nature of RCA.
- Explain Just Culture and its application.
- Review event using medical record and any other pertinent materials in preparation for the RCA.
- Provide RCA members access to relevant best practice/research documents/statutes and other literature to include hospital Policy and Procedure documents for reference.
- Conduct RCA in a manner consistent with Just Culture, using principles of human factors, systems theory, etc.

Executive or Governing Body Staff Responsibilities

Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.

Leadership

The Dignity Health St. Rose Dominican Board and campus Senior Leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety/Risk Management Program. These responsibilities are campus specific and include the following:

- Foster an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.
- Establish a culture in which communication flows freely regardless of authority gradient.
- Ensure that a define, on-going, proactive program for identifying risks to patient safety and reducing medical/healthcare adverse events is fully implemented and includes responses to actual and potential events;
- Ensure that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Provide for mechanisms to measure, analyze and manage variation in the performance of defined processes that affect patient safety;
- Allocate adequate resources, including personnel, time, information systems data associated with reducing risk and improving patient safety, and
- Active participation in the California Hospital Patient Safety Organization (CHPSO).

Physicians

Physicians are responsible, as participants in the Patient Safety/Risk Management Program for reporting events or near misses at each campus, and participating on focus teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (LIP) or comparable designee shall clearly explain these outcomes to the patient, and when appropriate, the family. (See Disclosure Policy)

Patients/Families/Visitors

Patients, families and patient representatives via written communication are encouraged to be active participants in their care and as such are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to the patient's health;
- Reporting their patient and outcome of treatment of that pain
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner, and
- Asking questions when they do not understand what they have been told about the patient's care, infection control, safety precautions and programs or what they are expected to do etc.

Patients and families/patient representatives/visitors will be provided with educational materials explaining these expectations and their role in reducing risk exposure and improving patient safety at the time of admission and throughout the patient stay utilizing various delivery methods including pamphlets, television and verbal communication. Some patients may also be included in the development process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

Hospital Departments and Staff

San Martin staff are key to promoting, identifying, and implementing activities to reduce risk and improve patient safety. Some of the activities include:

- Active participation in the activities to improve patient safety and the quality of healthcare delivered;
- Adherence to Infection prevention measures, the Joint Commission National Patient Safety Goals and other patient safety initiatives;
- Participation in education activities and process implementations;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among caregivers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in information needs assessment, staff surveys, and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all events and process variances (harm or no harm) even if they do not reach the patient (near miss).

The Patient Safety Committee

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the San Martin Campus and includes multidisciplinary team members which have oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow up on patient safety related trends, analysis results, changes in processes, policies and other areas to make as a result of identified needs.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Report and discuss sentinel events which include:
 - Number of sentinel events from previous calendar month (or quarter).
 - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
 - Evaluate the corrective action plan.

- Patient safety policies and checklists
 - At least annually evaluate Patient Safety policies and checklists
 - Revise the patient safety policies and checklists as needed.
 - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Patient Safety/Risk Management Plan

Goal	Plan	Due Date
Risk Assessments	1. Patient Safety/Risk Management to perform monthly risk assessments and report to PSC. 2. Infection Prevention to report to PSC findings of Risk Assessments.	Monthly PSC
FMEA	PSC to ensure one FMEA is conducted by Risk Management in CY 2019.	December 2019
Checklists	PSC will receive all new and renewed checklists used that impact patient safety whether directly or indirectly.	Monthly and ongoing
National Patient Safety Goals	PSC will support the posting of NPSGs throughout the hospital for staff reference.	Department leaders
Root Cause Analysis	RCAs will be conducted by Risk and Quality Management as soon as possible/practical after an event per Dignity Health policy	Ongoing
Manager orientation	Quality Risk Services will review/update Manager orientation.	March 31, 2019
Grievance Management	Grievances will be reviewed by the Grievance Committee to ensure compliance with CMS CoPs.	Quarterly and ongoing.
Staff and physician education	Patient Safety education will occur in various forms (e.g. Huddles, Department Meetings, Leadership Meetings, Posters) throughout the year.	Ongoing

Components and Methods

Proactive Risk Assessment Activities

The Patient Safety/Risk Management Department, in collaboration with the various facility committees including Infection Prevention, Quality Council and leadership will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk Assessment activities will include, but not be limited to the following:

- Patient Safety Risk Assessment evaluating known high risk processes/procedures that have associated risks,
- Review employee survey results to identify safety concerns,
- On-going risk assessments based on internal and external data, including sentinel event alerts,
- Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.
- Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of San Martin campus,
- Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.
- Patient Satisfaction surveys will include a question determining how the patient/family thinks the individual facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.
- Infection Prevention Surveillance Program.
- Additional staff surveys may be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety, as well as the staff's willingness to report medical/healthcare events.

Event Reporting

San Martin actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration and evaluation activities. As provided under the CHPSO (42 Code of Federal Regulations (CFR) Part 3 Section 3.20) the event report is considered a Patient Safety Work Product and as such is privileged and shall not be (1) subject to subpoena; (2) subject to discovery; (3) subject to disclosure and (4) admitted into evidence-provided such information is not subject to disclosure in certain criminal proceedings as described in regulation. (See Event Reporting and Management Policy).

- A. When an unplanned event/process variance occurs, the patient care provider will do the following:
 - a. Perform the necessary healthcare interventions to support the patient's clinical condition.
 - b. Perform the necessary interventions to contain the risks to others.
 - c. Notify the patient's attending physician.
 - d. Preserve any information related to the event including physical evidence. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Report and in the patients' medical record.
 - e. Notify immediate supervisor of the event.
 - f. Submit electronically an Event Report form or handwritten Event Report form to Risk Management/Patient Safety Services.

- B. Identification of potential unsafe condition that may affect patient safety:
 - a. Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
 - b. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention

- A. Patient safety related event reporting data within the scope of the Patient Safety Program and risk assessment results will be aggregated and presented routinely to various committees including but not limited to Medical Executive Committee (MEC), Medication Safety, Quality Council and Environment of Care for analysis and action. Based on analysis of this data and any actual or potential reviews, sentinel events and other internal and external data including TJC Sentinel Event Alerts, Dignity Health Shared Learnings, CHPSO trends, current literature, proactive action plan will be developed to include the following:
 - a. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
 - b. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
 - c. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
 - d. Redesign of the process and /or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
 - e. Test and implement the redesign process;
 - f. Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and
 - g. Implementation of a strategy for maintaining the effectiveness of the process over time.
 - h. Events that do not require a Root Cause Analysis will have an incident review completed by Quality/Risk Services Department as soon as practicable of becoming aware of the event. The results will be forwarded to leadership for review.

Response to Reported Adverse/Sentinel Events

Reporting of events is an essential component of a Patient Safety/Risk Management program. Through its participation in the CHPSO; all related investigation of events will be securely conducted, collected and documented as Patient Safety Work Product (PSWP) to maintain confidentiality as defined in the Federal Regulation.

- A. San Martin shall respond to all reported potential and actual adverse/sentinel events. (See Sentinel Event policy).
- B. Minimally, all adverse events will be analyzed utilizing a team of individuals including Risk Management/Patient Safety and Quality Departments, to conduct root cause analysis (RCA), incident review and/or a failure mode effects analysis (FMEA), implementation in action plan to reduce further risk to patients and establish measures of effectiveness.
 - a. The following events always elicit an intense analysis:
 - i. Confirmed transfusion reactions
 - ii. Significant adverse drug reactions
 - iii. Significant medication events and hazardous conditions

- iv. Minor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
 - v. Significant adverse events associated with anesthesia use.
 - vi. Hospital acquired infections
 - vii. All events meeting the definition of Sentinel Events in the State of Nevada.
 - b. A root cause analysis is performed when a sentinel or State reportable event occurs.
 - c. An incident review is performed when a near miss or other event with significant areas for improvement are identified.
- C. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
 - a. A “JUST CULTURE” approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
 - b. Involved staff should be involved in the RCA process.
 - c. The Department Manager will provide ongoing support to the staff member(s) as needed.
 - d. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

Education

- A. Staff Education
 - a. General orientation and other education and training programs as needed will emphasize specific job related aspects of patient safety and risk reduction strategies.
 - b. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
 - i. An overview of the Patient Safety Program
 - ii. Overview of TJC National Patient Safety Goals
 - iii. Staff’s role and responsibilities in the Patient Safety/Risk Management Program
 - iv. Event reporting criteria and process
 - v. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care
 - vi. Examples of specific job related aspects of patient safety.
 - c. Staff participating at a higher level of the Patient Safety/Risk Management Program will receive appropriate training necessary to understand and complete their assigned responsibilities.
- B. Physician Education
 - a. An overview of the Patient Safety/Risk Management Program will be provided to physicians at time of initial appointment and annually thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
 - b. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

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

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



Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in San Martin Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

Once the problems are identified, a Fishbone Diagram will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Whys technique also can be used to drill down the problem and find the root causes.

Model for Improvement

Please refer to the Dignity Health – St. Rose Dominican Performance Improvement Plan.

Data Collection and Reporting

Data should drive any quality and patient safety effort. San Martin is using IVOS for tracking the sentinel events, healthcare infection data, and Midas for internal data collection.

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

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

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>

Approval of Patient Safety Plan

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

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

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

Patient Safety Program Reporting and Review

All patient safety work product (PSWP) submitted through the CHPSO will be collected in the Patient Safety Evaluation System (PSES) for collection, management and analysis of information pursuant to the Patient Safety and Quality Improvement Act of 2005 (42 U.S.C. 299 et seq.).

- A. Patient safety/Risk Management related data and information reports will be provided routinely to various committees as previously identified including but not limited to medical staff, Quality Council and QCAC.
- B. A summary report of data, other internal and external information, as well as all actions taken by various committees and/or specific patient safety related teams will be submitted to the QCAC and the MEC.

- C. Annually, the Patient Safety/Risk Management Plan will be evaluated for effectiveness and the program updated to reflect the results of risk assessments related to patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.
- a. The review will be approved by QCAC.
 - b. Will be submitted to the Community Board for final review and approval.

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Reviewed/Approved:

Patient Safety Committee, January 2019

Quality Care Advisory Committee of the Board, January 2019

Community Board, January 2019

Spring Mountain Sahara
2019 PERFORMANCE IMPROVEMENT PLAN
2018 ANNUAL EVALUATION

During this period, the Performance Improvement Plan (PIP) focused on the important functions and processes of the organization to improve the quality of patient care, patient safety, and patient outcomes and to enhance the value of our services and to improve our operational efficiency. The goal of the PIP is to provide a framework and motivation for improvement of patient health outcomes and customer satisfaction by design of effective, organization-wide processes followed by measurement, assessment, and improvement of those processes.

Priorities for improving our systems and processes were based on our high risk, high volume, and problem prone processes and their outcomes such as:

- Seclusions and Restraints
- Standards Compliance
- Patient Grievances
- Patient Rights
- Treatment Plans
- Assessments of Patients
- Emergency Transfers
- Medication Safety
- Patient Safety
- Infection Prevention
- Discharge Planning
- Patient/Family Education
- Patient/Family Satisfaction
- Documentation
- Continuum of Care and Partial Hospitalization
- Community Needs
- Utilization Management
- Safety and Risk Management
- National Patient Safety Goals
- Sentinel Events and Root Cause Analyses
- Failure Mode Effects Analysis
- Performance Improvement Benchmarking
- Environment of Care
- Health Information Management
- Employee Surveys/Staff Retention
- Referral Source Satisfaction
- Staff Competency
- Contract Services
- Safety Culture Survey
- Hospital Based Psychiatric Inpatient Services (HBIPS) for Joint Commission

The Scope of the PIP included activities from the following structures:

- Direction and support from the Governing Board regarding policies, organizational management and planning.
- Participation from the Medical Staff in activities which measure, assess, and improve performance on an organizational-wide basis and by attending medical staff meetings.

- Direction and support from the Medical Executive Committee, action on reports from the medical staff committees and communication to the medical staff members.
- Direction and support from the leadership of the facility in the planning, implementation, coordination, and improvement of services.

Prioritization of Performance Improvement activities and monitoring of indicators:

- All indicators identified for monitoring will be based on ensuring patient safety and potential for risk to patients.
- Frequency/duration of monitoring and reporting will be determined by level of risk and compliance with benchmark set by Quality Council and approved by MEC and Governing Board.
- Indicators tracked and trended through the Performance Improvement process will be prioritized based on the results of the below performance improvement activities
 - Highest Risk
 - Results from FMEA on suicide risk assessments and AMSR implementation
 - Review of incident reports which identify trends which pose a high risk to patient safety
 - Medium Risk
 - Regulatory/state requirements
 - Lower Risk
 - Indicators found to be non-compliant
 - Lowest Risk
 - Statistically stable indicators

Evaluation of Activities

- The PI Committee continued to evaluate current practice and policies related to Joint Commission Standards. The Committee reviewed the results of the FSA and reported on Corrective Action Plans.
- Benchmarking on key clinical indicators within the division continued throughout 2018. Data collected continued to be reported showing rates per 1000 patient days and comparisons over time.

The UHS Dashboard was reviewed monthly in PSC and corrective action plans were created for indicators that trended above the UHS benchmark and/or UHS average score for that month. While the indicator for falls will be to continue be monitored, the focus will be working towards ensuring the suicide risk assessment is fully and accurately completed to ensure patient safety. The PSC will review and accept the FMEA once all action items are complete.
- Seclusion and Restraint rate goals for 2018 were made and rates were benchmarked. Rates were determined per 1000 patient days.

The overall physical hold rate and the overall seclusion rate for 2018 were below the UHS benchmark for the entirety of 2018. The indicator will be monitored monthly for a period of 3 months if the rate is above the benchmark in a single month.
- The hospital medication safety plan encourages all staff to report medication issues in a non-punitive environment. Nurses are actively involved in reporting potential medication variances and provide recommendations to improve our processes to prevent errors.

Nursing Leadership revised the medication audit and process again in 2017. The PI Committee and PSC will monitor for the effectiveness of the audit in 2018.

- The PI Council continues to review the effectiveness of the fall prevention program.

The Patient Safety Council focused on decreasing falls as the primary initiative in 2017. A PIT was created to focus on revising the detox protocols, education, flow sheets, etc. The PSC focused on improving patient education as a means to prevent falls, created a post-fall re-assessment, and revised the Fall Focus Study to include a debriefing component and implemented use of bed and wheelchair alarms, etc.

- Joint Commission's Hospital Based Inpatient Psychiatric Studies (HBIPS).
HBIPS-1: Assessment of violence risk, substance use disorder, trauma and patient strengths completed.

Remained at an average of 100% compliance throughout the year.

HBIPS-2: Hours of restraint use.

Remained below the UHS average.

HBIPS-3: Hours of seclusion use.

Remained below the UHS average.

HBIPS-4: Patients discharged on multiple antipsychotic medications.

Remained below the UHS average.

HBIPS-5: Patient discharged on multiple antipsychotic medications with appropriate justification.

This area significantly improved in 2017.

HBIPS-6: Post discharge continuing care plan created.

Remained at an average rate of 100% compliance throughout the year.

HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge.

Remained at an average rate of 100% compliance throughout the year.

SUB-1: Alcohol Use Screening. Met the goal of 90% or better compliance and was at 94% in Q4-19.

TOB-1: Tobacco Use Screening - This indicator was added in 2015 and in Q4-15, the Facility scored at 95%

TOB-2: Tobacco Use Treatment Provided/Offered - This indicator was added in 2015 and in Q4-15, the Facility scored at 100%.

TOB-2a: Tobacco Use Treatment Provided – This indicator was added in 2015 and the Facility scored at 100% in Q4-19.

IMM-2: Patient Influenza Vaccination – This indicator was added in October 2015. December 2018 the Facility was almost 90% compliant.

- Human Resources studies in conjunction with Risk Management reviewed staffing effectiveness, competency, recruitment and retention.

The turnover rate decreased toward the end in 2018. Staffing effectiveness is reviewed monthly via the incident reporting system, RCA analysis, and review of Good Catches. In 2017, the UHS Corporate Loss Control representative will continue to assist in reviewing all incidents and determining if there are staffing related concerns.

- Patient Grievances will be reviewed by the PI Council, Medical Staff, and the Governing Board.

The process was revised in 2017 and continued the process through 2018 to encourage staff to address patients' concerns directly instead of the patient waiting to speak with the PA. This resulted in a significant

decrease in Grievances and the Facility again met the goal of less than 5 grievances per 1000 patient days.

- Patient and Family Education indicators identified opportunities to improve multidisciplinary education.
Improving education was a large focus in 2017. Additional educational handouts were created, more booklets ordered. Implementing more education on detoxing and fall prevention was an area of focus in 2018. Education included staff and patients. Staff were provided an opportunity to participate in focus groups, Performance Improvement Teams related to the admit flow, and trainings on fall prevention and suicide risk assessment.
- Sentinel Event Alerts were reviewed, RCA's were completed as needed, and a Failure Mode Event Analysis was completed.
A FMEA was completed for patient falls. Several items were implemented due to the FMEA results. These items included the following: Education for patients/families, revisions to the fall assessment and policy, revising the detox protocols and flow sheets, and improvements to the environment.
- The 2018 National Patient Safety Goal changes were implemented and continuous monitoring of our compliance with previous Safety Goals was maintained.
The Sleep Apnea policy was revised based on the NPSG 6.
- Health Information and documentation requirements were monitored through a comprehensive retrospective clinical chart audit system. The audits include patient rights, medication management, assessments, treatment plans and discharge information. All findings were presented in numerical and graphs formats with quarterly findings, action plans and effectiveness of activities.
The Audit Tool was revised based on the Facility's current needs. Treatment Planning documentation continues to be an area with room for improvement. The DCS and CNO conducted multiple hospital wide trainings on proper completion of the treatment plan in 2017. This emphasis continued in 2018. Compliance with B tags were heavily trained on and audited for in order to ensure compliance.
- Performance Improvement Teams were organized and active to improve patient care.
The PIT for falls met 3 times in 2017 and 4 times 2018 until all agenda items are implemented.
- Outpatient Services monitored the continuum of care, attendance and referral rates, as well as patient satisfaction.
Patient satisfaction in Outpatient remains high, however return rates remain lower than goal. The OP Director will be revising the process for collecting surveys in order to increase the return rate. Outcomes measures were implemented to monitor patient improvement

Goals for 2019

- Continue to identify changes that will lead to improved performance and reduce the risk of sentinel events.
- Maintain compliance with Joint Commission Standards by continuously monitoring performance comparative to updated requirements.
- Analyze and improve on the outcomes related to HBIPS indicators by comparing results to company and national benchmarks in the PI Committee.

Implement the new HBIPS indicators for Tobacco and Alcohol Use. Ensure case managers are SBIRT trained so they can provide Brief Interventions. 100% compliance was achieved by middle of 2018. Implement the new indicators that are being released mid-year.

- Maintain the achievements of our performance improvement activities and continue to improve these processes, functions or services.
- Maintain compliance with all National Safety Goals. Re-educate staff on an ongoing basis regarding high risk issues.
- Reduce occurrences of restrictive interventions, falls, and medication variances.
- Complete a FMEA and develop action plans aimed at the goal of compliance .
- Conduct Security drills in main building and off-site locations.

Facility Name: Durango Outpatient Surgery Center	Policy And Procedure Guideline Name: Safety Management Program (Environment Of Care)	Policy Number: SAFE 104
	Subject Category: SAFETY	Effective Date: 12/2016
		Revised Date: 12/2017, 12/2018
		Page 1 Of 4

Policy: The facility shall provide guidelines and implement proactive practices, which provide a safe environment of care in relation to property, equipment, patients, personnel and the public. The facility and each OR must be designed and maintained so that all types of surgery can be performed in a manner that protects the lives and assures the physical safety of all individuals. ORs include not only traditional ORs, but also procedure rooms, including those where surgical procedures that do not require a sterile environment are performed.

Purpose: The reduction of physical hazards and the implementation of safe practices enhance environmental safety.

Procedure Guidelines:

Responsibility:

1. Facility leadership takes action to minimize identified safety risks in the physical environment. Employees are responsible for:
 - A. Intervention when, safety conditions pose a threat to life or health, or threaten damage to equipment or buildings.
 - B. The continuing maintenance of the facility property, eliminating hazards upon discovery.
 - C. Reporting equipment or maintenance problems and incidents of property damage to the Administrator/ Clinical Director upon discovery.
 - D. Reporting injuries and illness to the Administrator/Clinical Director.
 - E. Obtaining the information necessary to perform tasks in a manner that prevents injury to themselves, patients and others.

2. The Administrator/Clinical Director, and Safety Officer, as agents of the Quality Assurance Committee are responsible for:
 - A. Environment of Care development, implementation and monitoring.
 - B. Report of Safety Surveillance and activities to the Quality Assurance Committee/PI committee.
 - C. Every 12 months the organization evaluates the Environment of Care Plan for objectives, scope, performance and effectiveness.

Maintenance And Supervision:

1. Comply with the NFPA 101®, Life Safety Code® (LSC) for maintaining and supervising the facility grounds, buildings and equipment.
2. Maintain equipment and utilities following a preventative maintenance schedule.
3. Maintain sufficient light in the parking and entrance areas to reduce the potential for falls and security concerns.
4. Maintain signs and emergency systems to meet the needs of the visual and hearing impaired.
5. Maintain smoke free environment.
6. Provide facility cleaning, maintenance, and inspection, following a schedule for daily, weekly, monthly, semi-annual and annual activities.
7. Construction and Renovation (Interim Life Safety Plan):
 - A. Meet the existing ambulatory health care occupancy health code requirements for construction or renovation.
 - B. Train staff in alternative safety processes including the use of new specialized equipment and space.
 - C. Train staff to compensate for changes in Life Safety Plan.
 - D. Provide increased facility safety monitoring with construction and renovation included reference to the NFPA 101®, Life Safety Code® (LSC).
 - E. Inspect and monitor components of Life Safety Plan weekly or more frequently if indicated.

Risk Assessment:

1. Provide risk assessment and hazard surveillance to evaluate the impact of the center building, grounds, equipment, occupants, and internal physical systems on patient, employee and public safety.
 - A. Assign a Safety Officer to maintain risk and hazard surveillance.

- B. Record Hazard surveillance.
 - C. Report environmental hazard and safety surveillance to the Quality Assurance Committee. Provide follow-up to staff concerning safety issue recommendations.
2. Report and document patient, personnel or visitor injury, and occupational illness. Document incidents on a Variance Report, Occurrence Report, or Incident Report.
- A. Investigate and evaluate each report for opportunities to improve performance.
 - B. Include injuries and occupational illness in the report to the Quality Assurance Committee.

Product Safety Recalls:

1. Address a product safety recall upon notification.
- A. Inventory and remove recalled product from possible use.
 - B. Notify affected medical staff and evaluate a substitute product.
 - C. Inventory patients who may have received a recalled medical device from implant logs or records.
 - D. Consult with the Medical Director and/or Quality Assurance Committee to evaluate the situation and determine an appropriate method for patient notification if an implanted medical device has been recalled. The medical director, as an agent of the QA/PI committee reports the incident to the Medical Executive Committee.

Safety Education:

1. Provide Safety Education and Training at orientation and at least annually thereafter. Address general safety processes; area specific safety and job related hazards.
2. Provide Safety Guidelines in the General Orientation including:
- A. Review of Safety Policies and Guidelines.
 - B. Body Mechanics.
 - C. Hazardous Materials Communication.
 - D. SDS/ Hazardous Waste.
 - E. Safety Risk / Responsibilities.
 - F. Equipment Safety/Operations Manuals.
 - G. Emergency Preparedness.
 - H. Utility Systems and Electrical Safety.

- I. Infection Control/Exposure OSHA.
 - J. Reporting of Sentinel Events.
 - K. Variance, accidents/injuries, Security and Safety concerns.
 - L. Fire and Life Safety.
 - M. Safety Concerns.
 - N. Security.
 - O. OSHA.
3. Include specific safety standards related to safe practices and the safe use, inspection, cleaning and maintenance of specialized equipment in the Department /Job Specific orientation.
 4. Provide updates when new equipment is introduced.
 5. Review General Safety Guidelines annually.

Reference:

Center for Medicare and Medicaid Services (April, 2015). Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery.

The Joint Commission. (2017) Accreditation Standards and Requirements for Ambulatory Surgery Centers

EYE SURGERY CENTER OF NORTHERN NEVADA:

QUALITY AND PATIENT SAFETY PLAN

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

Commitment to Patient Safety

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

Mission, Vision, and Values

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

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

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

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

The plan focuses on the process rather than the individual, and recognizes both internal and

external customers, as well as facilitates the need of analyzing and improving processes.

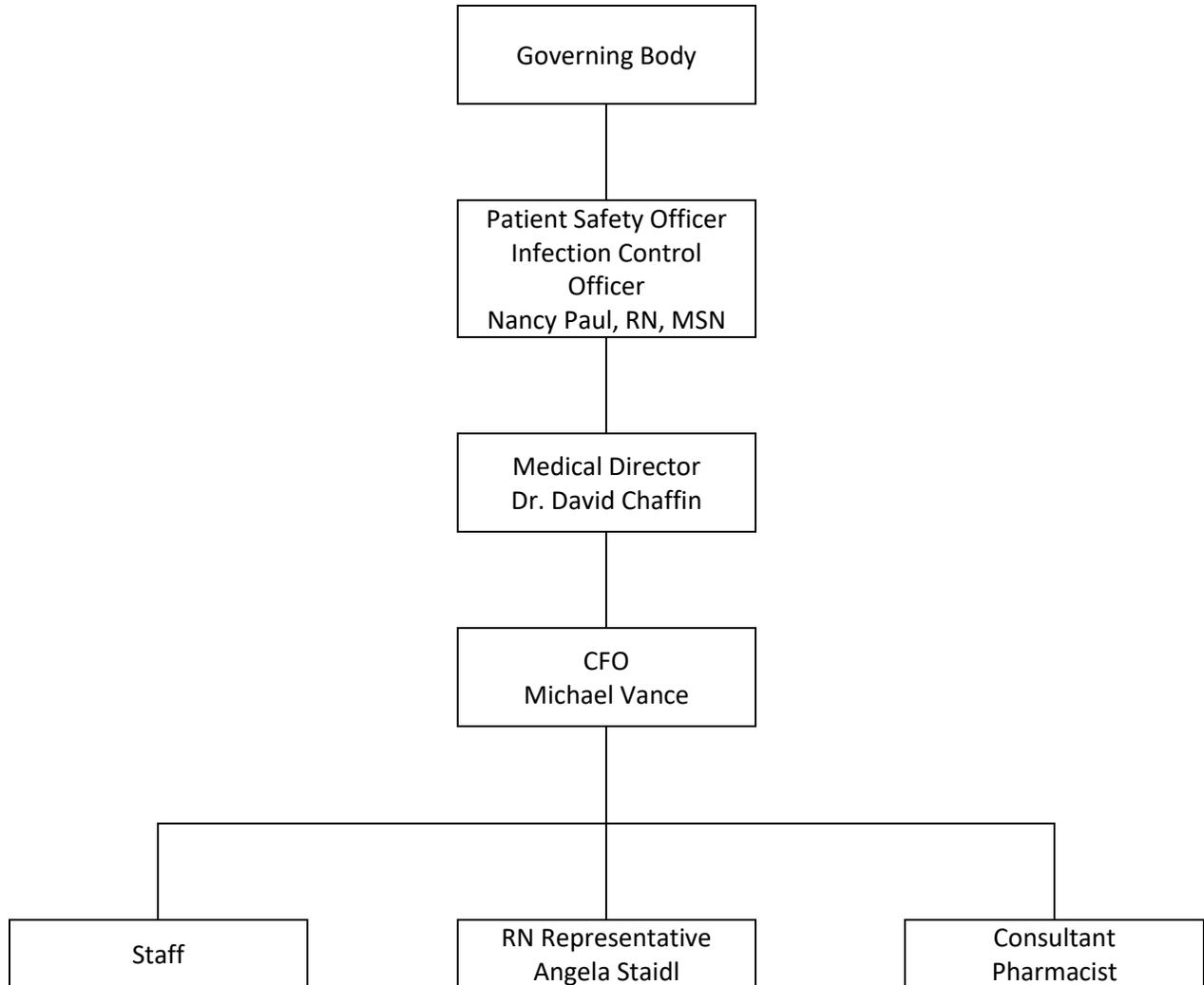
The core principles of this plan include:

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

Roles and Responsibilities

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

The Patient Safety Committee Organization



Roles and Responsibilities

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

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

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

The roles and responsibilities are defined below:

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

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

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

Root Cause Analysis (RCA) :

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

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

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

Executive or Governing Body Staff Responsibilities

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

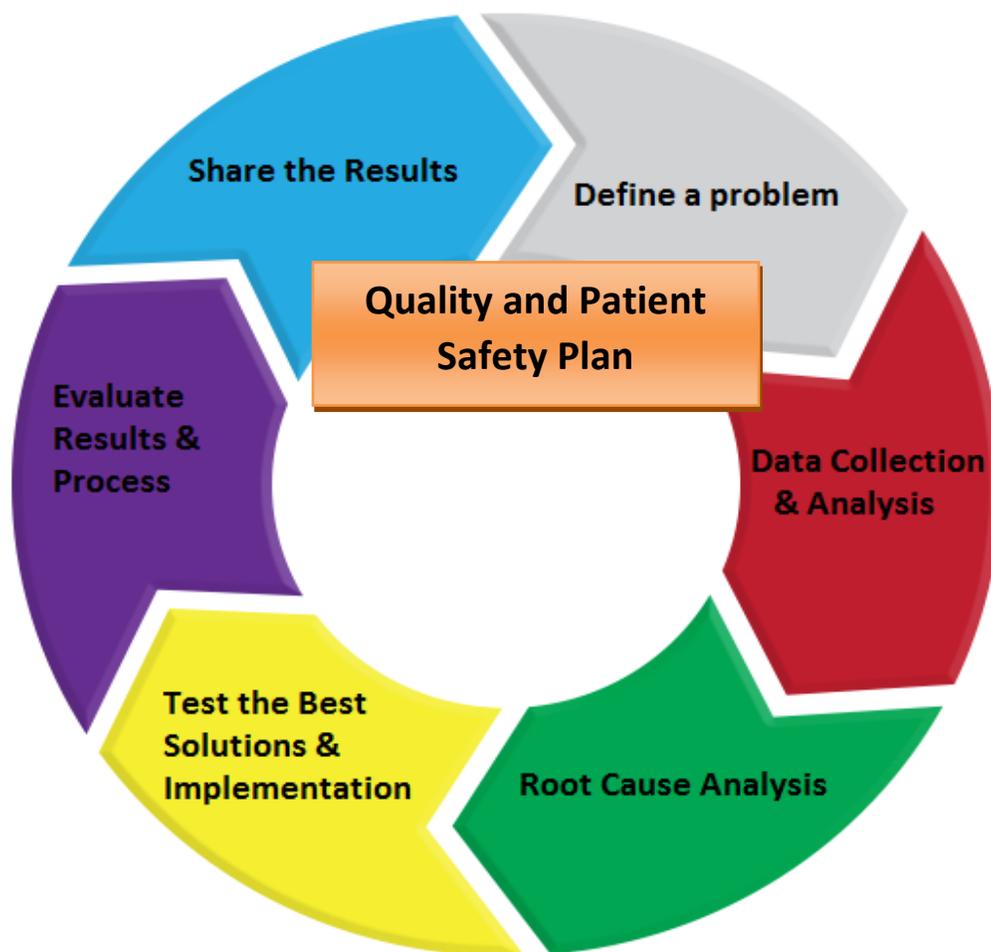
The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

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

Components and Methods

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

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



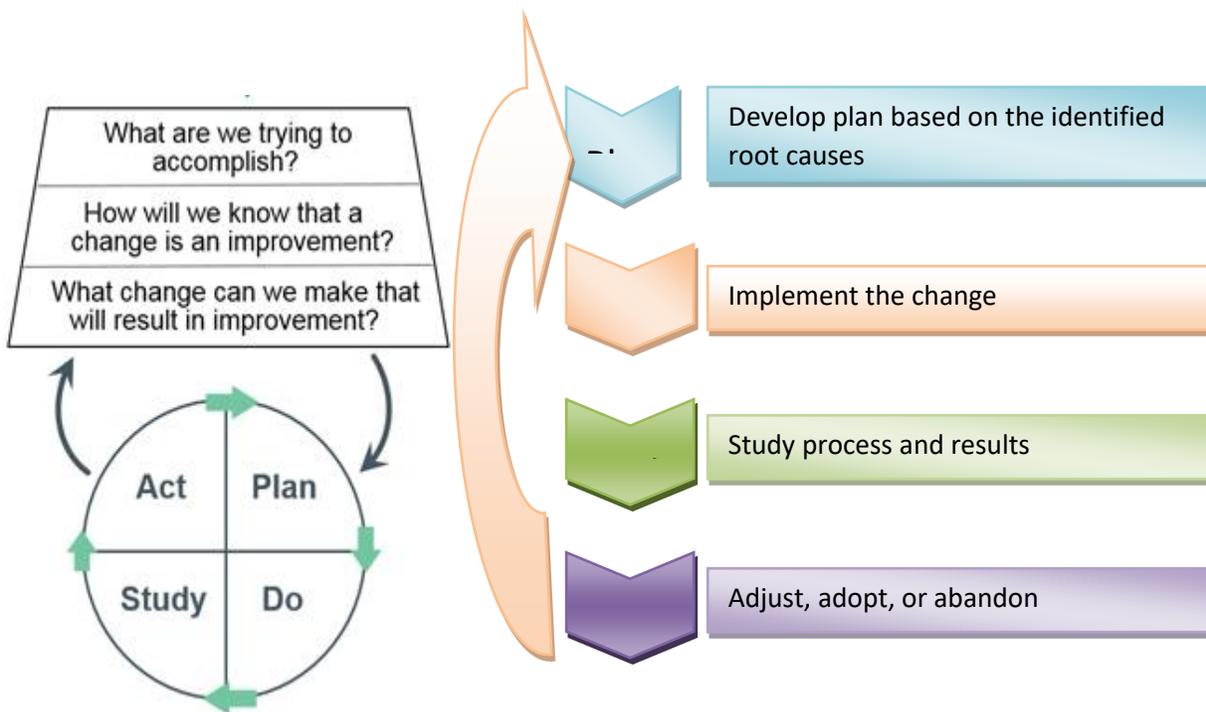
Root Cause Analysis

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

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

Model for Improvement

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



The cycle is defined as follows:

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

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

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

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

Data Collection and Reporting

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

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

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

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

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

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

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

The patient safety policies must include, without limitation:

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

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

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

Approval of Patient Safety Plan

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

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

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

**NEVADA ENDOSCOPY MANAGEMENT, INC
GASTROENTEROLOGY CONSULTANTS, LTD
RENO ENDOSCOPY CENTER, LLC
SOUTH MEADOWS ENDOSCOPY CENTER, LLC
CARSON ENDOSCOPY CENTER, LLC**

POLICY AND PROCEDURE MANUAL

Policy: Patient Safety Plan
Owner: Center
Date last updated: Revised 4/2016

Purpose: Gastroenterology Consultants, Ltd (GIC) and affiliated Endoscopy Centers are committed to ensuring the ongoing safety of our patients. To ensure the ongoing safety and care of our patients we follow specific guidelines and policies which, at a minimum, include:

I. Infection Control (IC): Refer also to the Infection Control (IC) Policy

1. Guidelines followed include:

- a. American Society for Gastrointestinal Endoscopy (ASGE) Multisociety Guideline on Reprocessing Flexible Gastrointestinal Endoscopes 2011
- b. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes 2015
- c. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standard of Infection Prevention in the Gastroenterology Setting 2015
- d. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Guideline for Use of High Level Disinfectants and Sterilants for Reprocessing Flexible Gastrointestinal Endoscopes 2013
- e. American Society for Gastrointestinal Endoscopy (ASGE) Infection Control during GI Endoscopy 2008
- f. Center for Disease Control (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007
- g. CDC Guide to Infection Prevention for Outpatient Settings 2014
- h. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the Elimination of Clostridium difficile in Healthcare Settings 2013
- i. CDC Safe Injection Practices

2. The IC Policy includes, at a minimum, processes or guidelines for:

- a. Patient selection and placement within the facility
- b. Infection Control Monitoring and Surveillance, Reporting
- c. Standard and Transmission Precautions, Hand Hygiene, Personal Protective Equipment, Respiratory Hygiene / Cough Etiquette and General Infection Control Practices in Healthcare Facilities as developed by the CDC and APIC
- d. Environmental and Terminal Cleaning
- e. Infection Control Officer

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

- f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

II. Patient Selection and Screening: Refer also to the Criteria for Scheduling Patients at ASC Policy.

1. To ensure patients are appropriate for the planned procedure in the planned setting patients undergo:
 - a. Pre-procedure scheduling evaluation with referral for office visit or consultation as appropriate
 - b. Pre-procedure assessment which includes at a minimum:
 - i. Review of past medical & surgical history
 - ii. Medication reconciliation, review
 - iii. Allergy and reaction, review of
 - iv. Physical assessment; assessment for communicable diseases
 - v. Vital signs

III. Patient Identification: Refer to Patient Identification Policy. Patient identity is verified with at minimum two (2) identifiers at check-in and at multiple points throughout care.

IV. Safe Surgery Checklist: Refer to Safe Surgery Checklist Policy. Patient and procedure are verified immediately prior to procedures.

V. Discharge Teaching: Patients are provided with written discharge instructions which are reviewed with patient and driver, as applicable, prior to discharge. Medications are reconciled prior to discharge if any new medications are ordered. Information specific to diagnosis, as best as known, is given to the patient. Patients are educated about signs and symptoms to report and given a twenty-four (24) hour telephone number to call in event of questions or concerns.

VI. Post Procedure Callbacks: Patients are contacted one (1) to two (2) business days post-procedure for follow up of any concerns and questions regarding discharge instructions.

VII. Pathology follow up: Patients are notified of pathology results and given information and follow up orders as applicable within two (2) weeks.

VIII. Pharmaceutical Services: Refer to Pharmaceutical Services Policy. Safe injection practices are strictly followed. Pharmaceutical services are overseen by a contracting pharmacist on a monthly basis.

IX. Quality Assurance and Benchmarking: Refer to the Quality Management Plan. More than one hundred (100) quality assurance checkpoints are monitored on per patient, per case, per day, per week or per month basis as applicable. Benchmarking of multiple facility and nursing care factors are completed on an ongoing basis. In addition, multiple procedure-related factors are tracked and trended in aggregate and specific to individual

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

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physicians on an ongoing basis. Incidents, procedure complications/events, adverse and sentinel events are investigated tracked and trended by facility, staff and physician. All data is reported to the Quality Management Committee.

- X. Staff Training:** Extensive staff training is done at time of hire. Annual staff retraining is mandatory; ongoing training is provided as applicable. Staff are evaluated for customer service and performance on an ongoing basis.
- XI. Checklists:** All items above are monitored via specific checklists, logs and or chart documentation.

Refer to:

- Infection Control Policy
- Criteria for Scheduling Patients at ASC Policy
- Identification of Patient Policy
- Pharmaceutical Services Policy
- Quality Management Plan
- Safe Surgery Checklist Policy
- Incident Reports Policy
- Complications: Procedure Event, Adverse and Sentinel Events Policy
- Staff Training Competencies and Logs
- NRS 439.865; 439.877

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

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RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – SAFETY PROGRAM

EFFECTIVE DATE: 10-12-07

REVISED: 2-28-12; 10-21-16

TITLE: Safety Program

SCOPE: All ROSC Staff

PURPOSE:

To adopt, implement and monitor a comprehensive environmental control program relative to safety and sanitation that involves staff, equipment operation and maintenance in order to provide a functionally and environmentally safe atmosphere for patients, personnel and visitors.

POLICY:

A Safety Committee will be established to implement the safety and environmental control program of the facility.

1. The safety committee will include: Administrator, Safety Officer, MD, Infection Control Officer, Pharmacy Consultant, and Clinical Manager.
2. Management will appoint a Safety Officer.
3. The Safety Committee will meet monthly as part of the Medical Advisory Committee.
4. Meeting minutes will be taken and maintained.
5. Committee findings and recommendations are reported and submitted in writing to the Quality Management Improvement and the Governing Board.
6. The Safety Officer will prepare the agenda and preside at the meetings. The Safety Officer is responsible for carrying out directives of the Committee and submitting reports to other committees.
7. The Committee members' responsibilities include reporting unsafe conditions, reporting all accidents or near accidents, investigating all serious accidents, contributing ideas and suggestions for improvement, making inspections, participating in In-service education and orientation, familiarizing themselves with standards for safety and sanitation, and assisting in policy and procedure development.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – SAFETY PROGRAM

EFFECTIVE DATE: 10-12-07

REVISED: 2-28-12

RESPONSIBILITIES OF SAFETY COMMITTEE:

1. To implement and review policies and procedures concerning functional safety and environmental control.
2. To function as a liaison with the Infection Control Officer.
3. To participate in the In-service Education and Orientation program.
4. To conduct Hazard surveillance.
5. To be knowledgeable regarding community safety agencies, especially those concerned with fire and other disasters.
6. To evaluate the effectiveness of the Safety Program and revise and update the program annually and as necessary.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – ANESTHETIC WASTE GASES

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Anesthetic Waste Gases

SCOPE: ROSC Management

PURPOSE:

To provide a safe environment for staff at the Reno Orthopaedic Surgery Center

POLICY:

There is a scavenger system attached to all anesthesia machines used at the center. Monitoring of waste gases is done quarterly by an outside service to assure that escaping gases are within a safe range.

PROCEDURE:

1. There will be a scavenger system connected to a separate vacuum from each anesthesia machine. The anesthesia practitioner makes sure that the hose is attached and inspected for leaks on a daily basis.
2. Quarterly inspections with written reports are obtained by an outside company qualified to test anesthesia waste gases. Management coordinates the inspection.
3. If any leaks are found on inspection, or the safe range is exceeded, the problem is immediately remedied before further use of the machine.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – CHECKLIST

EFFECTIVE DATE: 9-20-11

REVISED: 2-28-12; 2-20-15

TITLE: Checklist

SCOPE: ROSC Staff
Physicians
Contracted Vendors

PURPOSE:

Provide for protocols to improve the health outcomes of patients.

POLICY:

ROSC Safety Committee adopts the following criteria as a safety checklist for patient surgery.

According the WHO Guidelines for Safe Surgery 2009 the Reno Orthopaedic Surgery Center meets the following highly recommended objectives listed below.

Objective 1: The team will operate on the correct patient at the correct site
Universal Protocol

- Verification: Correct patient, site and procedure identified on the
 - Pre-op, Anesthesia and Intra op document.
- Marking: Preoperatively the patient participates along with the surgeon that marks the site.
- Time Out: Intra-operatively by the team and documented on the intraoperative record.

Objective 2: The team will use methods known to prevent harm from administration of anesthetics, while protecting the patient from pain

- Pulse oximetry & capnography are supplied and performed by an anesthesiologist or directed by a physician.
- Circulation is monitored and documented in surgery and post op by anesthesia and nursing.
- Temperature is monitored and recorded pre-op, intra-op and post op.
- Consciousness is monitored and recorded pre-op, intra-op and post op.

Objective 3: The team will recognize and effectively prepare for life-threatening loss of airway or respiratory function

- Airway is assessed and documented by anesthesia on the anesthesia record.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – CHECKLIST

EFFECTIVE DATE: 9-20-11

REVISED: 2-28-12; 2-20-15

- A difficult intubation cart is equipped and ready for use by anesthesia.
- Only credentialed anesthesiologist provide anesthesia at ROSC.

Objective 4: The team will recognize and effectively prepare for risk of high blood loss

- Large volume blood loss is not anticipated in a majority of the cases performed at ROSC
- The anesthesiologists communicate with the surgeon and evaluate each case appropriately.
- The Medical Director evaluates all questionable cases prior to surgery.
- IV's are established prior to each surgical case.
- Blood loss is recorded on the anesthesia record.
- Blood is not administered at ROSC.

Objective 5: The team will avoid inducing an allergic or adverse drug reaction for which the patient is known to be at significant risk

- Credentialed anesthesiologists administer pharmacologic agents.
- Nursing administers medication under a physician order.
- Both physician and clinical staff are responsible for identifying the patient and the medication administered.
- A Patient Medication Reconciliation Record (signed by the patient), is obtained prior to surgery.
- Allergies and sensitivities are recorded on the front of the chart.
- Allergies and sensitivities are checked and recorded on the pre-op, intraop, PACU and anesthesia records.
- Aseptic medication technique is performed upon hire and annually.
- Medication drawn up and labeled is administered by the same person drawing and labeling the medication.
- National patient safety goals for the medication are followed by ROSC.

Objective 6: The team will consistently use methods known to minimize the risk for surgical site infection

- Prophylactic antibiotics are administered to all surgical cases prior to surgery by the anesthesiologist.
- Sterilization process involves the use of indicators used on every tray and peel pack. A Biological is run each load.
- A surgical scrub for OR is done for 2-5 minutes.
- Sterile surgical attire is provided for each surgical case.

Objective 7: The team will prevent inadvertent retention of instruments and sponges in surgical wounds

- Sponge and sharps counts are performed before and after each procedure and documented on the intra-op record.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL*APPROVED BY: BOARD OF DIRECTORS*

*SECTION: SAFETY – CHECKLIST**EFFECTIVE DATE: 9-20-11**REVISED: 2-28-12; 2-20-15*

Objective 8: The team will secure and accurately identify all surgical specimens

- All specimens have a patient label attached to the container.
- Pathology Specimen Request is complete and accompanies the patient specimen.

Objective 9: The team will effectively communicate and exchange critical information for the safe conduct of the operation.

- The team prepares for instruments, implants, intra-operative imaging, and pathology in advance of each case.
- Anesthesia issues are addressed by each anesthesiologist and surgeon prior to each case. When patient safety is in question, the case is cancelled.

Objective 10: Hospitals and public health systems will establish routine surveillance of surgical capacity, volume and results.

- ROSC Facility will report the following Outcomes to the Nevada State Bureau of Health & Welfare Annually
 - Number of operating rooms –
 - Number of procedure rooms –
 - Number of surgical procedures performed
 - Number of board certified Orthopaedic surgeons –
 - Number of Anesthesiologist
 - Day of surgery mortality rate
 - Post operative in hospital mortality rate
 - Surgical Site Infection Rate
 - Surgical Complications

2) All treatment provided is ordered by the physician.

3) Any prescription given to the patient is filled at the patients' pharmacy of choice. Medication is taken as directed by the surgeon and pharmacist and documented on the discharge instruction sheet.

4) All after care and all other discharge instruction are given as ordered by the physician and documented on the discharge instruction sheet.

5) An environmental, staff and patient safety checklist is completed monthly the safety officer. (attached)

6) Orientation checklist – (attached).

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – COMPRESSED GAS HANDLING

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Compressed Gas Handling

SCOPE: ROSC Staff

PURPOSE:

To provide guidelines for safe handling of compressed gas.

POLICY:

IDENTIFICATION:

1. All gases are properly labeled with contents and whether they are flammable.
2. Never rely on the color of the tank for identification of the contents.

STORAGE & HANDLING:

1. Tanks of compressed gases are stored upright and chained to a support system to minimize falling over.
2. A safety cap is used during transport of H-cylinders.
3. Always use proper DISS or pin index safety system for the gas being used.
4. The gas storage area is kept cool and out of direct rays of the sun and away from heat pipes. It is well ventilated to prevent "pocketing " of fumes, and is fireproof with some means for cooling in the event of fire.
5. Regulators, fittings or gauges will never be lubricated or come in contact with oil or grease.
6. Never use leaking or defective tubing or equipment that is in need of repair.
7. When opening cylinder valve, always open with the face pointed away from any person.
7. Care should be taken to handle tanks safely. Seek assistance if tank is too heavy to handle alone. Never handle tank with greasy hands.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – COMPRESSED GAS HANDLING

EFFECTIVE DATE: 10-12-07

REVISED:

DISPOSAL:

1. All anesthesia gas scavenging systems are vented to the outside.
2. Empty cylinders and tanks are returned to the distributor.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – ELECTRICAL SAFETY

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Electrical Safety

SCOPE: All ROSC Staff

PURPOSE:

To provide guidelines for general electrical safety

POLICY:

1. All staff will observe for signs of electrical hazards. Equipment with frayed cords, exposed wire, or broken plugs will be taken out of use immediately. A sign that states "DO NOT USE" will be placed on equipment, and Management notified. Management will have the equipment repaired by the biomedical engineer.
2. Extension cords will be used only on an emergency basis.
3. All electrical devices being used in the operating room must have three-pin plugs and connect into three-hole receptacles.
4. Cheater plugs will never be used.
5. Keep fluids away from all electrical equipment.
6. Remove power plugs by grasping the plug; never pull on the cord.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – ELECTRICAL SAFETY CHECKS

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Electrical Safety Checks

SCOPE: Biomedical Engineering Contractor
Management

PURPOSE:

To assure that patients and employees are protected from electrical shock.

POLICY:

All electrical appliances or equipment destined for patient care is to have an electrical safety check performed before use in the facility with annual safety checks performed thereafter.

PROCEDURE:

1. Management or designee contacts the Biomedical Engineer to perform electrical safety inspections before new electrical equipment is used.
2. The Biomedical Engineering Contractor inspects the equipment and places a label stating when the inspection took place and that the item is safe for use.
3. The Biomedical Engineering Contractor has a contract with ROSC to inspect new equipment and to perform annual inspections on all electrical equipment.
4. During routine inspections, if equipment is found to be defective or hazardous, Management is informed and a decision is made as to whether the item will be replaced or repaired.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – GENERAL SAFETY IN THE WORKPLACE

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: General Safety In The Workplace

SCOPE: All ROSC Staff

PURPOSE:

To identify general safety rules for all employees of ROSC.

POLICY:

All employees of the Center will be familiar with the following safety rules of the workplace. Employees will be responsible to observe and correct any hazards in the workplace.

1. Keep traffic areas clear of obstructions.
2. Pick up any foreign matter on floors and put in proper receptacles.
3. Wipe up spills immediately.
4. Use caution when opening doors. If no viewing window is present, open door slowly.
5. Be physically and mentally prepared for work.
6. Prevent spread of infectious disease by staying out of the workplace when ill.
7. Never engage in horseplay or practical jokes.
8. Walk, never run in the facility.
9. Heed all warning signs that caution a hazardous condition. (i.e., wet floor signs.)
10. Know location of fire alarm pulls, extinguishers, and exits.
11. Be familiar with Emergency Codes.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – INSTALLATION OF ALCOHOL BASED HAND RUBS

EFFECTIVE DATE: 8-30-10

REVISED:

TITLE: Installation of Alcohol Based Hand Rubs

SCOPE: Management

PURPOSE:

To maintain a safe environment

POLICY:

ROSC will follow CFC 416.44 (b) Standard: Safety from Fire.

(5) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if—

(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

iii) The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and

(iv) The dispensers are installed in accordance with the following provisions:

(A) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m);

(B) The maximum individual dispenser fluid capacity shall be: (1) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors. (2) 0.5 gallons (2.0 liters) for dispensers in suites of rooms;

(C) The dispensers shall have a minimum horizontal spacing of 4 ft (1.2m) from each other;

(D) Not more than an aggregate 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet;

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – INSTALLATION OF ALCOHOL BASED HAND RUBS

EFFECTIVE DATE: 8-30-10

REVISED:

(E) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code;

(F) The dispensers shall not be installed over or directly adjacent to an ignition source; and

(G) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL*APPROVED BY: BOARD OF DIRECTORS*

SECTION: SAFETY – LATEX ALLERGY

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10

TITLE: Latex Allergy**SCOPE:** All ROSC Staff**PURPOSE:**

To provide for a latex safe environment for patients with known latex allergies. To help prevent or minimize the risk of an allergic anaphylactic reaction secondary to exposure and sensitization to latex.

POLICY:

When possible, schedule procedure as first case of the day, otherwise plan for a latex safe environment.

PROCEDURE:

- 1) Notify all health care providers of potential or known latex-allergic patient before scheduled procedure.
- 2) Exchange latex-free products for all latex-containing items.
- 3) Notify surgeon and anesthesia care provider if no alternative latex free product is available.
- 4) Remove latex items from OR unless no non latex alternative exists.
 - a. Remove boxes of latex gloves and replace with non-latex gloves (e.g., sterile, nonsterile).
 - b. Double check all supplies and equipment for latex and remove any latex-containing items.
- 5) Educate patient about latex-safe plan.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – MEDICAL DEVICE PROBLEM & RECALL

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Medical Device Problem & Recall

SCOPE: All ROSC Staff

PURPOSE:

To establish a uniform policy to ensure that product problem and recall information is documented, disseminated and reported according to Federal guidelines.

POLICY:

The following steps will be performed by Management for all reported product alerts and product problems:

1. When a product alert is received, Management determines if the product is stocked in the surgery center.
2. If the product is in ROSC, appropriate action takes place according to instruction of the recall. This may include revision of usage instructions, removal of the product, or modification of the product.
3. Staff and physicians are notified by Management as to the proper action to follow.
4. If the product has been used on a patient, the manufacturer and the patient are notified.
5. If a product is used on a patient and malfunctions during use, the manufacturer must be notified and if any injury or potential injury has occurred, an incident report is filled out.
6. If a medical device has in all probability caused death, serious injury or illness of a patient, the FDA and the Nevada Department of Public Health and Environment must be notified. Management or Administrator files the appropriate reports.
7. The report to the FDA must be made within ten days after the facility becomes aware of the problem. The report includes the facility name and address, the device's name, serial number and model number; the manufacturer's name and address and a brief description of the event reported to the manufacturer.

SECTION: SAFETY – MEDICAL DEVICE PROBLEM & RECALL

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

EFFECTIVE DATE: 10-12-07

REVISED:

8. The "Occurrence Report – Equipment Malfunction or Misuse" form must be completed and submitted to the Nevada Department of Public Health and Environment (within one (1) business day of the occurrence. (See copy of form following this policy.)

9. A copy of the recall or problem and a copy of the reports to the FDA and applicable State reports is kept on file in the facility.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – PATIENT SAFETY PLAN

EFFECTIVE DATE: 12-20-11

REVISED:

TITLE: Patient Safety Plan

SCOPE: All ROSC Staff

PURPOSE:

To provide ongoing safety and care for patients.

POLICY:

1. Guidelines followed:
 - a. CDC Guideline for Hand Hygiene
 - b. ANSI/AAMI Comprehensive guide to steam sterilization and sterility assurance in health care facilities. Supported by CDC Guideline for Sterilization and Disinfection in Health Care Facilities.
 - c. CDC Environmental Infection Control in Healthcare Facilities
 - d. AORN Peri-Operative Standards and Recommended Practices
 - e. APIC Text of Infection Control and Epidemiology Guideline for Isolation Precautions
2. Additional Infection Control Policies – See Infection Control in Policy Manual for details
 - a. Aseptic Technique
 - b. Communicable Disease Reporting
 - c. Environmental Controls
 - d. Facility Sanitation
 - e. Housekeeping Logs
 - f. Infection and Complication Tracking
 - g. Laundry Guidelines
 - h. Operating Room Sanitation
 - i. Pest Control
 - j. Sterilizer Monitoring
 - k. Traffic Patterns
 - l. Wound Classification
 - m. Universal Precautions
3. Patient Selection and Screening
 - a. Patients are pre-screened by the Surgeons and Medical Director for appropriateness for surgery.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL*APPROVED BY: BOARD OF DIRECTORS*

SECTION: SAFETY – PATIENT SAFETY PLAN

EFFECTIVE DATE: 12-20-11

REVISED:

- b. Patients with known infections and communicable disease are not a candidate for surgery at the facility.
 - c. In the event that an infection or communicable disease is discovered at the facility the patient is isolated and appropriate discharge is determined by the physician. Reports are made to the appropriate agencies.
4. Patient Identification
 - a. Identity is verified with two identifiers upon admission and prior to any procedure or treatment.
5. Timeout: Timeout is performed prior to procedure or surgery.
6. Discharge Teaching
 - a. Written discharge instructions are reviewed with the patient and significant other prior to discharge.
 - b. Patient medication is reconciled prior to discharge and a copy of their Medication Reconciliation Sheet is given to the patient.
 - c. Patients are educated to report general as well as specific signs and symptoms related to the procedure.
 - d. Patients are given a telephone number where they can reach a surgeon 24 hours a day.
7. Post Procedure Call
 - a. Two attempts to call the patient post procedure is made one business day following the procedure.
8. Pathology results
 - a. Pathology results are sent directly to the surgeon's office.
 - b. A designated ROSC nurse follows up on all pathology results and verifies that the surgeon received and reviewed the results
9. Pharmacy
 - a. ROSC has a consulting Pharmacist who reviews, updates and educates staff on policy and procedure related to Medications. (See Medication section of Policy and Procedure)
 - b. The consulting Pharmacist performs a monthly audit of the Controlled Substances, DEA 222 forms, anesthesia narcotic reconciliation, patient charts.
 - c. The Pharmacist produces a monthly report, recommendations and corrective actions are made to Management, Medical Director and the Medical Advisory Committee as deemed necessary.
10. Quality Management and Improvement

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – PATIENT SAFETY PLAN

EFFECTIVE DATE: 12-20-11

REVISED:

- a. Clinical data is collected on however not limited to the following: transfers to an acute facility, infections, patient falls, other patient complications, medication incidents and medical device issues.
 - b. Quality Improvement Studies are performed to analyze issues for improvement.
 - c. Data is reported to the Medical Advisory Committee and Board of Directors.
11. Staff Training
- a. Staff training is provided on hire, annually and as needed.
12. Checklist and Logs
- a. Checklists and logs cover but are not limited to the following: safety, staff skills, cart checks, temperatures and expirations.
13. Policies, Quality Management and Fire and Disaster Manual detail staff and patient safety.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL*APPROVED BY: BOARD OF DIRECTORS*

SECTION: SAFETY – RADIATION SAFETY

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 10-21-16

TITLE: Radiation Safety**SCOPE:** Physicians
Clinical Staff
Radiology Technicians**PURPOSE:**

To provide guidelines that will limit exposure to radiation to personnel and patients in ROSC.

POLICY:

1. All personnel in the operating room will wear a lead shield while x-rays are being taken. Personnel wearing lead aprons should always face the x-ray unit.
2. Leaded shields will be used, when possible, to protect the patient's reproductive organs and thyroid during x-rays. The circulating nurse will document the type of protection used on the patient.
3. All reasonable means of reconciling an incorrect count should be implemented before using an x-ray to locate an unaccounted item.
4. Lead aprons will be laid flat or hung by the shoulders when not in use, to minimize cracking of shield.
5. The C-arm equipment will be inspected and calibrated annually by a state physicist, to ensure the equipment is working properly and meets safety regulations. Aprons and shields will be x-rayed bi-annually for any breaks in integrity. Any damaged aprons and shields will be disposed of.
6. All staff members working in the presence of fluoroscopy will wear dosimetry badges. Dosimetry Badges will be maintained and monitored.
7. All staff who are assigned a dosimetry badge will be requested to report all other badge reports on an ongoing basis in order to help keep track of cumulative exposure.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – RADIATION SAFETY

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 10-21-16

8. The staff member assigned to operate the fluoroscopy equipment must carefully observe all radiation safety precautions and remind other medical personnel if radiation safety rules/practices are violated. Violations of radiation safety rules/practices must be documented and reported to Management.
9. Personnel are limited to receiving no more than the maximum permissible radiation dose limit per State or Federal guidelines.
10. Reproductive organ shielding shall be provided to all patients unless this area is essential to the clinical image.
11. All fertile female patients will be evaluated for the potential of pregnancy.
12. Thyroid shields will be worn by staff if they are in proximity to the patient.
13. The facility has an established BioMed agreement for the maintenance of all radiation equipment.
14. Any questions regarding radiological safety must be directed to Management who will contact the contracted X-ray technician or the state physicist.
15. Signs will be posted on OR or procedure room door when x-ray is in use.
16. A yearly radiation safety competency will be completed by all staff.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – REFRIGERATOR MONITORING

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Refrigerator Monitoring

SCOPE: ROSC Staff

PURPOSE:

To insure medications and food that require refrigeration are kept at proper temperature.

POLICY:

The temperature in the refrigerator used for storage of patient food or medication must be kept between 36 degrees and 46 degrees Fahrenheit.

PROCEDURE:

1. Medications and food is stored in separate refrigerators.
2. Refrigerators containing patient food or medications have a thermometer.
3. Staff checks the refrigerator temperature daily.
4. The temperature is recorded daily on the flow sheet. Flow sheet is filed with Management and kept for two years.
5. If there is a variance from the recommended temperature, the nurse notifies maintenance to have the refrigerator checked.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL*APPROVED BY: BOARD OF DIRECTORS*

*SECTION: SAFETY – REPORTING OF DEFECTIVE EQUIPMENT/INSTRUMENTS**EFFECTIVE DATE: 10-12-07**REVISED:*

TITLE: Reporting of Defective Equipment/Instruments

SCOPE: All ROSC Staff

PURPOSE:

To define the protocol to be used when an instrument or piece of equipment is not working properly. To assure that equipment and instruments that are defective are removed from the system until they are repaired.

POLICY:

Any item that is found to be defective is tagged and sent to Management.

PROCEDURE:

1. When an instrument or any piece of equipment in the Operating Room or Recovery Room is found to be defective, the employee discovering the problem tags the item and removes it from service. Management is notified so action can be taken to have the device repaired or replaced.
2. The employee labels the item and describes the exact problem that was observed, to improve rapid repairs.
3. Management further investigates and has the item sent for repair as needed. Management communicates with the staff that the item has been sent out of the department for repair and if a loaner can be expected.
4. Upon return of the item, the device is checked by a staff member who is familiar with the performance or, if necessary, it is evaluated by the Biomedical Engineering Contractor prior to being returned to service.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – SAFE USE OF STERILIZER

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Safe Use of Sterilizer

SCOPE: OR Staff/Sterile Processing

PURPOSE:

To assure safe use of sterilizers and prevent injuries from occurring when sterilizers are used.

POLICY:

Any staff member who will be using autoclaves will be educated and trained in the safe and proper operation of the sterilizer.

PROCEDURE:

1. Employees participate in an inservice on the use of the sterilizer. They demonstrate that they can safely operate the autoclaves, and are familiar with the manual operation of the autoclaves.
2. The chamber door is opened slowly and never opened until the pressure gauge reads zero. Never look directly at the autoclave when opening the door. Excess steam may have accumulated and be released when the door is opened.
3. When removing items from the autoclave, mitts, towels or forceps are used. Never reach in the autoclave with bare hands or arms.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – SAFETY PRECAUTIONS WHEN USING OXYGEN

EFFECTIVE DATE: 10-12-07

REVISED:

TITLE: Safety Precautions When Using Oxygen

SCOPE: All ROSC Staff

PURPOSE:

To assure safe handling of oxygen in the facility.

DISCUSSION:

Oxygen is a non-flammable, non-explosive gas, however it readily supports combustion. Any material that will burn in air will ignite more readily in an oxygen-enriched atmosphere. The higher concentration of oxygen, the greater is the intensity of burning. When oxygen is administered, the following precautions must be taken to prevent explosions and fire.

POLICY:

1. The facility is a “no smoking” facility. “No Smoking” signs are posted and visitors are reminded of this policy.
2. Any defect in the oxygen administration system such as a leak or a malfunctioning flow meter must be reported to Management who contacts the appropriate service for repair or replacement of the part.
3. Oxygen equipment must have an oxygen pressure interlock system and fail safe mechanism.
4. All electrical cords and equipment must be grounded.
5. Materials such as oil, grease, alcohol and other highly flammable substances must be kept away from oxygen and oxygen equipment.
6. Be sure there is no oil on hands when handling any oxygen administration equipment.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – SAFETY WHEN MOVING PATIENTS OR OBJECTS

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10

TITLE: Safety When Moving Patients or Objects

SCOPE: All ROSC Staff

PURPOSE:

To provide guidelines for moving patients and objects to avoid injury to staff.

POLICY:

PROCEDURE:

1. Lifting:
 - a. Look over the object to be lifted, making sure it is not too heavy or clumsy to handle alone.
 - b. Stand close to the object with feet apart for balance. Make sure footing is secure.
 - c. Bend knees. Keep back as straight as possible.
 - d. Get a good grip and keep the weight close to your body.
 - e. Lift gradually. Straighten knees and stand. Use leg muscles. Avoid quick, jerky motions.
 - f. When the weight is too heavy or the object is too bulky to lift safely, get help.
2. Pushing and pulling objects:
 - a. Get a good grip on the object; hands inside handles.
 - b. Keep back as straight as possible.
 - c. Brace your feet for maximum leg power.
 - d. Bend your knees to get the best use of your body weight.
3. Carrying:
 - a. Keep the load close to your body.
 - b. Make sure your vision is clear and the load does not obstruct your view.
 - c. Do not change grip while carrying the load.
 - d. Always face the spot on which the load will rest.
4. Transferring:

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – SAFETY WHEN MOVING PATIENTS OR OBJECTS

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10

- a. Lock bed, recliner or wheelchair
- b. Explain transfer steps
- c. Encourage independent movement from the individual
- d. Keep individual close to the body
- e. Follow steps for lifting
- f. Transfer to locked bed, recliner or wheelchair
- g. Secure individual

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL

APPROVED BY: BOARD OF DIRECTORS

SECTION: SAFETY – USE OF SIDE RAILS

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10

TITLE: Use of Side Rails

SCOPE: All Staff

PURPOSE:

To assure the safety of patients who have had sedation or anesthetic drugs.

POLICY:

PROCEDURE:

1. The side rails of stretchers are put in an upright position if the patient has been given a preoperative sedative.
2. All patients transported on a stretcher must have the side rails in an upright position.
3. When the procedure is complete and the anesthetized patient is moved to the stretcher, the side rails are put in an upright position and remain up until the patient is transferred to a recliner or discharged.

RENO ORTHOPAEDIC SURGERY CENTER, LLC

POLICY MANUAL*APPROVED BY: BOARD OF DIRECTORS*

SECTION: SAFETY – SENTINEL EVENTS

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 2-27-15

TITLE: Sentinel Event**SCOPE:** All ROSC Staff**PURPOSE:**

To identify and report to appropriate health regulatory agencies events resulting in unexpected outcomes. A thorough investigation for root cause analysis, implementation of improvement to reduce risk, and monitoring of the effectiveness of process improvement will occur following any reportable event.

DEFINITION:

Per NRS 439.830 defines a sentinel event as: an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function.

POLICY:

Any event identified below is reported to the Department of health and Human Services Nevada Division of Public and Behavioral Health. All occurrences are reported by the next business day.

A written report using the format provided by the State, is completed and returned within 5 days of the occurrence. Prevention is encouraged through safe practices by the healthcare team.

REPORTABLE OCCURRENCES:

As of October 1, 2013 reportable events to the state Sentinel Registry include:

Surgical or Invasive Procedure Events

- A.** Surgery or other invasive procedure performed on the wrong site
- B.** Surgery or other invasive procedure performed on the wrong patient
- C.** Wrong surgical or other invasive procedure performed on a patient
- D.** Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- E.** Intraoperative or immediately postoperative/post procedure death in an American Society of Anesthesiologists Class 1 patient.

Product or Device Events

- A.** Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
- B.** Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
- C.** Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.

Patient Protection Events

- A.** Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
- B.** Patient death or serious injury associated with patient elopement (disappearance)
- C.** Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a health care setting.

Care Management Events

- A.** Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- B.** Patient death or serious injury associated with unsafe administration of blood products
- C.** Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
- D.** Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
- E.** Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- F.** Any Stage 3, Stage 4, and un-stage-able pressure ulcers acquired after admission/presentation to a healthcare setting
- G.** Artificial insemination with the wrong donor sperm or wrong egg
- H.** Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
- I.** Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

Environmental Events

- A.** Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
- B.** Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
- C.** Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- D.** Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

Radiologic Events

Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

Potential Criminal Events

- A.** Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- B.** Abduction of a patient/resident of any age
- C.** Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
- D.** Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.



QUALITY AND PATIENT SAFETY PLAN

Lake's Crossing Center

500 Galletti Way
Sparks, NV 89431
775-688-1900

Commitment to patient safety

Lake's Crossing Center provides statewide residential and outpatient services to individuals who have been evaluated as requiring mental health services in order to proceed with their adjudication. Such services require a fully coordinated effort with responsibilities for treatment, evaluation and consultation. Lake's Crossing Center must meet a wide range of needs for a diverse population and we are committed to a comprehensive approach for continuous improvement of patient safety.

Mission, Vision and Values

The purpose of this policy is to establish a plan for patient safety designed to promote patient safety throughout all departments in Lake's Crossing Center. Thus, the plan will focus on system-wide integrated performance improvement activities aimed at assuring an integrated approach to patient safety. In support of our commitment to patient safety, Lake's Crossing Patient Safety and Quality Improvement program includes oversight regarding:

- Providing the necessary services to clients in the least restrictive manner appropriate to the client, utilizing collaboration of leadership, medical staff and other staff providers to deliver integrated and high quality care within the program.
- Consultation and collaboration with other Division agencies on the treatment and management of clients.
- Providing treatment oriented toward development of socially appropriate and community-oriented skills stabilizing potentially dangerous behavior.
- Ensuring appropriate placement and follow-up of clients adjudicated not guilty by reason of insanity or un-restorable to competency.
- Continuing education of staff and medical personnel to assure quality of care and monitoring of standards.

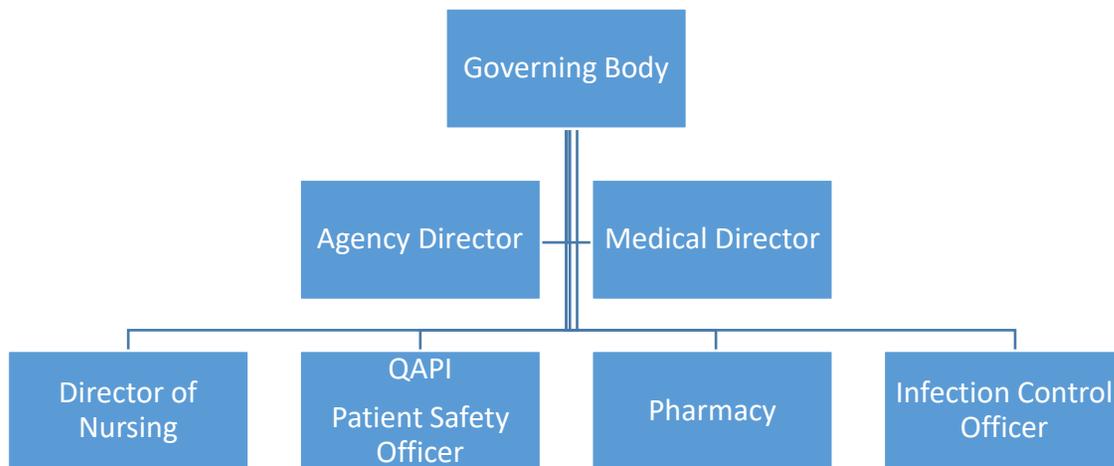
Scope and Purpose

The scope of the Patient Safety Plan is agency wide and includes all aspects of patient safety, visitor safety, vendor safety and employee safety. All staff in Lake's Crossing are required to fully support and participate in this plan and devote their expertise to the patient safety and quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the clients and facilitate our accountability to the courts. The plan further focuses on the processes involved and facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions regarding implementations of the Patient Safety Plan will be based on data and facts and will be reported to and tracked by the QAPI department.

As per NRS 439.875, a medical facility shall establish a Patient Safety Committee. This Patient Safety Committee should ensure that the Quality and Patient Safety Plan is promoted and executed successfully. The Patient Safety Committee organizational chart for Lake's Crossing is as follows:



Roles and Responsibilities of the Patient Safety Committee:

- Meet at least once a month
- Receive reports from the Patient Safety officer as per NRS 439.870
- Evaluate the actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at Lake's Crossing.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of clients who receive care at Lake's Crossing.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections at Lake's Crossing.
- Make recommendations to the governing body to reduce the possible number and severity of sentinel events and infections that could occur at Lake's Crossing.
- Report to the governing body at least once each quarter regarding the number of sentinel events occurring at Lake's Crossing during the preceding calendar quarter; the number and severity of infections that occurred at Lake's Crossing during the preceding calendar quarter; any identified recommendations to reduce the number and severity of any sentinel events and infections that occur at Lake's Crossing.

- Adopt and put into use, patient safety checklists and patient safety policies, as required in NRS 439.877, review the checklists and policies annually and revise as determined by the patient safety committee.
- On or before March 1 of each year, submit a report to the Director of the Legislative Counsel Bureau that will be transmitted to the Legislative Committee on Health Care. This report is to include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review.

Roles and Responsibilities of the Patient Safety Officer:

- Serve on the Patient Safety Committee
- Conduct root cause analysis through utilization of interviews, analysis, investigation and corrective action plan implementations.
- Perform the duties as required in NRS 439.835 regarding the reporting of sentinel events.
- Take such action as is determined to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at Lake's Crossing.
- Report to the Patient Safety Committee regarding any action taken in accordance with the above responsibilities.

Roles and Responsibilities of the Infection Control Officer:

- Serve on the Patient Safety Committee
- Monitor the occurrences of infections at Lake's Crossing to determine the number and severity of infections.
- Report to the Patient Safety Committee concerning the number and severity of infections at Lake's Crossing
- Take such action as is determined to prevent and control infections as identified at Lake's Crossing.
- Carry out the provisions of the infection control program pursuant to NRS 439.865 and ensure compliance with the program.

Roles and Responsibilities of the Governing Body

- Provide vision, leadership and oversight to the Patient Safety and Quality Improvement process and develop and foster a safe learning and improving culture at Lake's Crossing.
- Plan, discuss, and work with the committee and its members in accomplishing the patient safety goals and activities.

Objectives, Goals and Assessment of the Quality and Patient Safety Plan

Pursuant to NRS 439.837, Lakes Crossing will utilize the proper procedures to report any sentinel events and conduct an investigation concerning the causes or contributing factors and implement a plan to remedy the causes or contributing factors of the sentinel event through the use of Root Cause Analysis. Also considered for analysis will be near misses, repeated problems such as medication errors and events which have or could have resulted in patient harm. The objective will be to determine where gaps lie and how to determine them; not to place a blame in any particular department or individual.

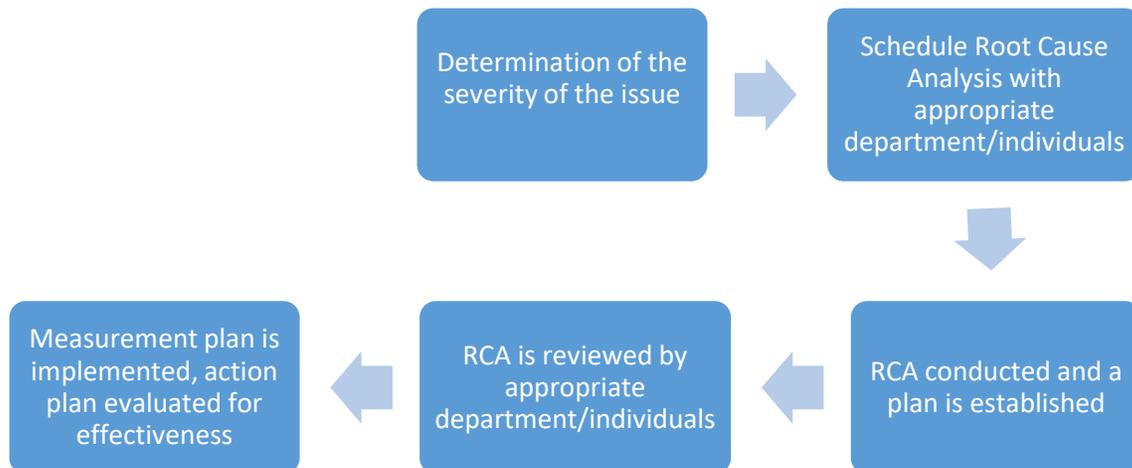
The event will be analyzed based on the factors of *catastrophic, major, moderate and minor*. The probability will be measured on the frequency – is it a frequent occurrence, occasional occurrence, uncommon occurrence or remote occurrence.

TABLE 1: Safety Assessment Matix

Severity 	Catastrophic	Major	Moderate	Minimal	Comments
Frequent	3	3	2	1	
Occasional	3	2	1	1	
Uncommon	3	2	1	1	
Remote	3	2	1	1	

The above matrix will be used as a determining factor for if a Root Cause Analysis would be necessary for the incident with “3” being the highest rating.

Upon identification of an incident necessitating a Root Cause Analysis a meeting will be held with determination steps as follows:



According to NRS 439.865, the patient safety plan must include certain required checklists relating specifically to our facility. The specific checklists which are **required** to be included are listed below as well as others pertinent to Lake’s Crossing Center.

Patient Safety Checklists and Patient Safety Policies:

Check Lists Include:	Usage	Existing	Developed	Reviewed	Revised
Documentation of physician orders	Nursing	Yes	Yes		
Discharged client room cleaning inspection	Janitorial	yes	Yes	Yes	
Discharge instructions	Nursing, Social Services	Yes	Yes	Yes	
Pharmacy error tracking	Pharmacy	yes	Yes	Yes	
Fall Prevention	Nursing	yes	Yes	Yes	
Sanitation QA checklist	Janitorial	yes	Yes	Yes	
Food service meal incident communication log	Nutritional Services	Yes	Yes	Yes	
Eyewash station	Janitorial	Yes	Yes	Yes	
Chemical sanitizing dish machine log	Nutritional Services	Yes	Yes	Yes	
Refrigerator & freezer logs	Nutritional Services	Yes	Yes	Yes	
Patient Safety Policies Include:	Usage	Existing	Developed	Reviewed	Revised
Two personal patient identifiers	All Staff	yes	Yes	Yes	
Nationally recognized standard precautions protocol	All staff	Yes	Yes	Yes	Yes
Nationally recognized hand washing procedures	All staff	Yes	Yes	Yes	
Infection control policies	Nursing	yes	Yes	Yes	Yes

Summary of Review	Total # Developed	Total # Reviewed	Total # Revised
Patient Safety Checklists	10	10	
Patient Safety Policies	4	4	2

Ongoing Reporting and Review:

Monthly	Quarterly	Annually
1) Sentinel Event monthly report	1) Sentinel Event quarterly report	1) Report submitted to LCB
2) Severity of infection report	2) Severity of infection quarterly report	2) Quality and Patient Safety plan update
3) Meeting of the Patient Safety Committee	3) Review and evaluate the measure of improvement of patient safety	3) Checklists and policies reviewed and revised as necessary
4) Monitoring of contract personnel	4) Review and evaluate the measurement to prevent and control infections	

SUBJECT: PATIENT SAFETY IN THE PROCEDURE ROOM	REFERENCE #7002
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE: 1
	OF: 3
APPROVED BY:	EFFECTIVE: 02/15/2010
	REVISED: 01/19/11

PURPOSE:

To identify and eliminate potential safety hazards, thereby reducing risk to patients, personnel and visitors.

POLICY:

Patient safety refers to a systematic facility-wide program to minimize preventable physical injuries, accidents and undue psychological stress during the visit. The HSC nursing practice for safety standards is as follows:

1. Patient Identification:

The RN always identifies the patient by checking the wristband with the patient's chart and the operating schedule. In addition, the RN verifies patient identification through verbal communication with the patient and/or caregiver.

2. Patient Observation:

Side rails are always to be in the UP position when a patient is on a gurney. Special care is ensured by provision of an adequate number of personnel when positioning patients. When positioning patients, it is essential to provide supportive devices to protect nerves and blood vessels. Limbs are never to be hyperextended.

3. Dedication to Meticulous Aseptic Technique:

Facility team members must know and apply the principles of aseptic technique at all times to avoid life- threatening postoperative infection.

4. Use of Operating Equipment:

All equipment and appliances must be set up and used according to the recommendations and instructions of the manufacturer. All new electrical equipment must be inspected prior to use and every six (6) months thereafter by the biomedical engineer. Electrical equipment must be properly grounded to prevent electric shock and burns.

5. Prevention of Burns:

All electrical equipment must be inspected by the bio medical contractor prior to use.

SUBJECT: PATIENT SAFETY IN THE PROCEDURE ROOM	REFERENCE #7002
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE: 2
	OF: 3
APPROVED BY:	EFFECTIVE: 02/15/2010
	REVISED: 01/19/11

6. Administration of Drugs:

All drugs used by the anesthesiologist are logged in the anesthesia record.

7. Preparation of Specimens:

- Tissue removed from a patient is sent to the Pathology Laboratory and labeled with the site of the specimen as ordered by physician.
- It is the responsibility of the physician to communicate to the RN the origin of each specimen.
- It is the responsibility of the RN to label and record each specimen accurately.
- All specimens for frozen section are placed in a dry container and forwarded to the Pathology Laboratory.

8. Fire Safety:

Response of the facility's staff to a fire is outlined in the Fire/Emergency Management Plan. Facility personnel participate in the quarterly fire drills as appropriate and review fire precautions in the annual recertification program.

9. Emergency Management Responses:

Response of the facility team in a disaster situation is outlined in the Fire/Emergency Management Manual. Facility personnel participate in disaster drills and review emergency management precautions in their annual recertification program.

10. Equipment Maintenance:

All operating room equipment is inspected for operational integrity by facility personnel prior to each use. Equipment is to be removed from service immediately, if needed repair or a malfunction is evident.

11. Disposal of Waste:

All infectious (bio hazardous) wastes, including glass, are single red-bagged, placed in the special collection container marked "Bio hazardous Waste" and disposed of by contracted medical waste company.

SUBJECT: PATIENT SAFETY IN THE PROCEDURE ROOM	REFERENCE #7002
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE: 3
	OF: 3
APPROVED BY:	EFFECTIVE: 02/15/2010
	REVISED: 01/19/11

12. Disposal of Needles and Syringes:

Used needles and syringes are disposed of by placement in a rigid sharps disposal container which is present in each operating room. When container is 3/4 full it is capped and disposed of in the bio hazardous waste collection container.

13. Use of Adapters:

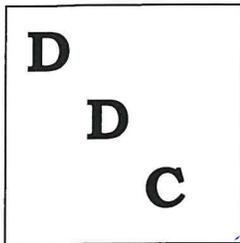
Adaptor use within the facility is prohibited.

14. Anesthesia Safety:

Refer to Anesthesia Policy and Procedures' for other anesthetic safety standards.

15. Visitor Safety:

Visitor safety in the facility is based on the safety practices and standards developed by the facility Safety Committee. All visitors entering the facility shall be instructed by the appropriate supervisor as to proper attire and safety hazards. Visitors who are injured in the facility are referred to the Administrator for evaluation and treatment. Visitor injuries are summarized on an unusual occurrence form by the supervisor and forwarded to administration. The facility Safety Committee reviews visitor injury reports, identifies hazardous conditions and recommends preventive measures.



**P A T I E N T S A F E T Y
P O L I C Y & P R O C E D U R E**

Policy:

The policy set forth by the Digestive Disease Center (DDC) is to ensure patient safety, before, during, and after a patient's procedure.

Procedure:

- A. Each patient will have a history & physical examination documented in their chart within 7 days prior to their procedure.
- B. Each patient will complete the Medical History Questionnaire prior to his or her procedure.
- C. All patients will receive a copy of the Patient Rights and Responsibilities at the time of scheduling of procedure.
- D. All medical staff is CPR certified, and aware of the location and use of all emergency equipment. All DDC Physicians are ACLS certified.
- E. At least one ACLS certified Registered Nurse is staffed when patients are present in the facility, along with ACLS trained Anesthesiologist is present with sedated patients.
- F. Once a patient has been admitted to the facility, non-sedated patients are visualized frequently to ensure needs are met. Sedated patients are monitored closely checking vital signs with observation to assure patients are free from complications related to the procedure and /or medical problems
- G. Each patient will meet the required discharge criteria set forth by DDC, and ANOR anesthesia standard, prior to being discharged. The physician will have the final decision, to discharge the patient, which will be documented, signed and become part of the patient's record.
- H. A written physician discharge order will be issued to each patient post procedure, providing them with post procedure instructions, precautions, and contact information in case of an emergency. A copy of this document will become part of the patient's record.
- I. The facility staff will make a follow up appointment for the patient as ordered by the physician.
- J. Each patient will be contacted within 24 hours after having their procedure to ensure that they are not experiencing any complications related to the procedure.
- K. A patient safety committee will be formed to include one physician from each site, the nurse manager from each site, the pharmacy consultant, and the medical director. The committee will meet quarterly to discuss patient safety.

Centennial Hills Hospital Medical Center

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2019

I. Overview

Centennial Hills Hospital endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. Centennial Hills Hospital operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that Centennial Hills Hospital remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by Centennial Hills Hospital to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan ("Plan") provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at Centennial Hills Hospital. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the "Just Culture" concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with Centennial Hills Hospital policies. Centennial Hills Hospital employees, contractors, vendors, and members of each facility's medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

Centennial Hills Hospital mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

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

Centennial Hills Hospital recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

Centennial Hills Hospital has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk

Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon NRS 439.870 includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on NRS 439.873, responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to NRS 439.865 and ensure compliance with the program.

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

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

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

Centennial Hills Hospital has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. Centennial Hills Hospital has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

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

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with NRS 439.875, the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on NAC 439.920, a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

Centennial Hills Hospital's PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon NRS 439.875 and NRS 439.877, include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4)(b).
- Receive reports from the Patient Safety Officer pursuant to NRS 439.870.
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.

- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Centennial Hills Hospital is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title "Risk Manager," this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the

Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. Risk Connect (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

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

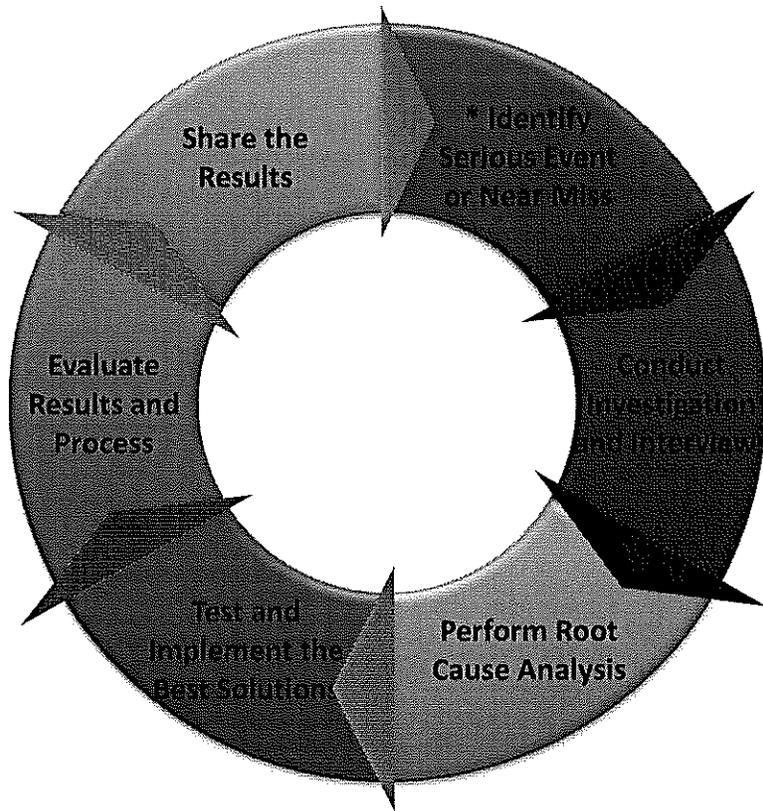
A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

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

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. UHSD Acute Care Division Patient Safety Priorities, Goals and Objectives for 2019

- **Surgical and Procedural Safety:**
 - **Wrong Site Surgery.**

- Monitor through MIDAS, Cerner, PSO reports, Pharmacist Interventions. Report monthly with oversight by CPSC.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls in the acute division by end of 2019.
 - Monitor through MIDAS event reporting. Report quarterly with oversight by CPSC.
- Centennial Hills Hospital as hospital specific goals of:
 - Decreasing the fall rate from 2.45 to ≤ 2.25
 - Decreasing the number of reportable hospital acquired pressure ulcers by 10%
 - Increase grievance closure in 7 days from 82% to 90% for the year
 - Complete formal risk assessments of :
 - Behavioral Health
 - Critical Care

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

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

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

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

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by 2002 Special Session, 13; A 2005, 599; 2013, 217)

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: (NRS 439.802)

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

(Added to NRS by 2005, 599; A 2009, 553)

Medical facility (NRS 439.805)

“Medical facility” means:

- A hospital, as that term is defined in NRS 449.012 and 449.0151;
- An obstetric center, as that term is defined in NRS 449.0151 and 449.0155;
- A surgical center for ambulatory patients, as that term is defined in NRS 449.0151 and 449.019; and
- An independent center for emergency medical care, as that term is defined in NRS 449.013 and 449.0151.

(Added to NRS by 2002 Special Session, 13)

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and

Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Box Canyon Surgery Center

Policy Name:	PATIENT SAFETY
Section:	Safety
Policy #:	IV.4.2
Purpose	Staff Education

Approved Date	Reviewed Date	Revised Date
2-3-09	2-23-10, 2-23-11, 2-6-12, 2-4-13, 2-24-14, 2-6-15, 3-28-16, 3-29-17, 2-21-18	

- Keep stretcher in low position with side rails raised when patient is unattended.
- Assist patient when getting on or off stretcher.
- Never leave post-sedated patient unattended in restroom.
- Always lock stationary stretchers and wheelchairs to prevent falls.
- Offer assistance to patient dressing or undressing to prevent falls.
- Any spillage of water or liquid substance will be cleaned up immediately to avoid falls.
- Patients should not walk around without shoes.
- Patients may not drive themselves home after being sedated.
- Be aware of patients, family and your working environment and watch for safety hazards.



CARSON TAHOE
— HEALTH —
Continuing Care Hospital

PATIENT SAFETY PLAN

Carson Tahoe Continuing Care Hospital

2019

Effective: February 2005 (combines Organization Safety and Patient Safety Plans)
Revised: October, 2005
Revised: December, 2006
Revised: December, 2007
Revised: January, 2009
Revised: January, 2010
Revised: January, 2011
Revised: January, 2012
Revised: February, 2014
Revised: November 2014
Revised: January 2016
Revised: January 2017
Revised: January 2018
Revised: January 2019

INTRODUCTION

The Carson Tahoe Continuing Care Hospital is a part of Carson Tahoe Health System, a Nevada not-for-profit hospital. We are committed to patient safety, quality patient care and quality patient outcomes consistent with our Mission and Core Values.

MISSION

To enhance the health and well being of the communities we serve.

CORE VALUES

Putting patients first and treating everyone with dignity and respect.

PURPOSE

The Patient Safety Plan provides a planned, systematic, coordinated approach for continually improving the health and safety of patients who are treated at the medical facility, by reducing patient harm and maintaining a safety culture.

PLAN

- Established Patient Safety Committee:
 - Mandatory Membership to include:
 - Patient Safety Officer
 - Infection Control Officer
 - At least 3 providers of health care team who treat patient at the medical facility, including one medical, nursing and pharmaceutical staff
 - In 2016 added Lead Pharmacist, C.NA, Nurse Manager, Respiratory Therapist, Physician, & Physical Therapist
 - One member of the executive or governing body
 - Committee required to meet monthly.
- Inclusion of
 - Infection Control Program to prevent and control infections within the medical facility (this is a document separate from the Patient Safety Plan that meets the requirements for NRS 439.865)
 - Patient Safety checklists and patient safety policies as required by NRS. 439.877
 - 2019 Checklist Inventory *Attachment A*
 - Annual review and revision of checklists and policies
- Annual Report to Legislative Committee on Health Care
- Integration of all patient safety activities both ongoing and developing
- Ongoing orientation, education and training to emphasize specific job related aspects of patient safety to maintain and improve staff awareness
- Encourage internal reporting of medical / healthcare incidents and events, effectively respond to actual occurrences, manage occurrences and events with a non-punitive approach, and focus on processes and systems to minimize individual blame and retribution

- Periodic survey of the staff regarding willingness to report, actions taken and outcomes of occurrences and events
- Internal reporting of findings, actions taken and resolution; organizational learning and communication of occurrence and event information
- Consideration of patient safety priorities when designing and redesigning of relevant processes, functions and services
- Involvement and education of patients, their families about their role in facilitating safe delivery of care, identifying potential risks and suggesting improvement to patient safety

SCOPE OF ACTIVITIES

The Carson Tahoe Continuing Care Hospital (CTCCH) Patient Safety Committee integrates all components of safety into the organizationwide safety program in collaboration with the Carson Tahoe Health System Quality, Environmental Safety, Infection Control, Patient Care areas, Risk Management, Compliance and Ethics.

Patient Safety Committee activities include:

- Sentinel Events pursuant to NRS Chapter 439
 - Review alleged events reported to State of Nevada, RCA investigations and resulting action plans.
 - Recommendations to the executive or governing body for reducing the number and severity of sentinel events and infections that occur
 - Provide emotional support for staff involved in incidents or events, through Human Resources, leadership, department supervisors and other resources as appropriate
 - Report at least quarterly to the executive or governing body
 - The number of sentinel events occurring in the previous quarter
 - The number/severity of infections occurring in the previous quarter
- Review and evaluate Quality Measures
 - To improve the patient safety and outcomes
 - To reduce and/or prevent infections
- Monitor patient/ environment safety issues identified throughout the organization
- Promote internal and external knowledge and experience to prevent patient harm, adverse events and occurrences, to maintain and improve patient safety
- Review aggregated or trended data including: No harm events, Mild or moderate adverse outcomes, Near miss, Medication events, Adverse drug reactions, Transfusion reactions, Hazardous conditions, Present on admission / Hospital acquired conditions, Online incident reports,
- Utilize a proactive approach to recognize and acknowledge medical/healthcare events and risks to patient safety, initiate actions and recommendations to reduce or prevent these events and risks
- Prioritize and recommend Patient Safety activities, as appropriate.
 - Utilizing trended data from Environmental Safety, Security, Employee Health, Emergency Management, Lab or Radiation Safety, Utilities Management, Bio Med, Fire Drills or Inspections.

PATIENT SAFETY OFFICER

The Patient Safety Officer is designated by the medical facility and has administrative responsibilities as prescribed by NRS chapter 439 (specifically outlined in NRS 439.815 through

NRS.439.875) and by other regulatory agencies and accrediting bodies. Duties and responsibilities include but are not limited to:

- Serving as Chair of the Patient Safety Committee
- Supervising sentinel event reporting to the State
- Conducting mandatory investigations; developing and implementing action plans
- Ensuring notification as appropriate within the medical facility

STRUCTURE

The CTCCH Patient Safety Reporting Structure Model *Attachment B* visually diagrams the reporting structure.

Attachment A

Carson Tahoe Continuing Care Hospital 2019 Checklist Inventory		
Checklist title	Checklist Category	DEPT
Discharge Checklist	Discharge	Electronic Health Record
Fire Drill Participation	Environment	Housewide
Fire Report	Environment	CTH Facility Staff/Spruce Engineering
Fire Watch Form	Environment	CTH Facility Staff/Spruce Engineering
Life (Fire) Safety Inspection / Business Occupancy	Environment	CTH Facility Staff/Spruce Engineering
Life (Fire) Safety Inspection /Healthcare Occupancy	Environment	CTH Facility Staff/Spruce Engineering
Patient Room Housekeeping Checklist by area /by shift		
Environmental Rounds Performed by Charge RN each shift	Environment	Nursing
Quality Assurance Checklist	Environment	Housekeeping
Unit Department Checklist	Environment	Nursing
CRASH CARTS		
Adult Crash Cart Check List	Other Safety	Nursing
AED Checklist	Other Safety	Nursing
Refrigerator / Freezer Temperature Record	Other Safety	Nursing/Pharmacy/Dietary
Blanket Warmer Temp Logs (1)	Other Safety	Nursing
Ventilator Calibration Checklist	Other Safety	Respiratory
Central Line Associated Blood Stream infection and CAUTI surveillance	Other Safety	Infection Control & Nursing
Emergency Equipment checklist	Other Safety	Nursing Administration/Emergency Preparedness
Hand Hygiene	Other Safety	Infection Control
Infection Control Monitoring during construction	Other Safety	Infection Control
Central Line Insertion	Other Safety	Nursing
Charge Nurse checklist	Other Safety	Nursing
Hand Off Communication sheet Pre-op/OR/PACU	Treatment	Receiving CTH facilities
Magnetic Resonance Imaging History & Assessment	Treatment	Medical Imaging
Medical Imaging Invasive Procedure Checklist	Treatment	Medical Imaging
Non Ionic and/or Ionic Contrast Consent Form	Treatment	Medical Imaging
Foley Catheter Tracking	Treatment	Infection Control & Nursing

Attachment B

CTCCH Patient Safety Reporting Structure



STRUCTURE

The Hospital Board of Directors has the ultimate responsibility for Patient Safety.

The CTCCH Director of Nursing oversees the Hospital Safety Program and, as appropriate, reports Patient Safety and Quality activities and issues or concerns directly to Administration and the Hospital Board of Directors.

The CTCCH Director of Nursing is the hospital Patient Safety Officer. The Patient Safety Officer has the administrative responsibilities as prescribed by Nevada State law NRS chapter 439 (specifically outlined in NRS 439.815 through NRS 439.875, other regulatory agencies and accrediting bodies.) The Patient Safety Officer chairs the Patient Safety Committee which reports at least quarterly to the Hospital Board of Directors, and reports to the Medical Staff via Quality Management Committee and Medical Executive Committee as needed.

2018 Patient Safety Plan

"The key to reliable, safe care does not lie in exhorting individuals to be more careful and try harder. It lies in learning about causes of error and designing systems to prevent human error whenever possible" (IHI, 2008, p. 19).

i

Mission Statement

Seven Hills Hospital

"It is the Mission of Seven Hills Hospital to improve the quality of life for our patients, their families and communities by providing consistently excellent and compassionate behavioral health and substance abuse treatment services."

Patient Safety

Through a robust Patient Safety Program, the Patient Safety Committee fulfills its commitment to aiming for the elimination of medical errors through the use of best practice and setting the standards of excellence of quality mental health care.

Guiding Principles

The Patient Safety Plan is a conceptualized model of care founded on the belief that a just culture holds the key to a patient safety focused organization. Seven Hills Hospital supports a just culture and focusses on analyzing structural, process, and outcome measures and using an evidence-based approach to support interventions.

Data and safety monitoring is a system for auditing and analyzing outcome data from continuous research. The Patient Safety Committee provides guidance for clinical staff while confirming compliance to organizational goals of providing a safe and therapeutic environment that enhances recovery. Patterson (2011) reported on an innovative quality improvement success describing an interview with an Infection Prevention Coordinator, who credited their success in overcoming communication barriers by stating that "if workers own the solutions and share them with their colleagues, the solutions are adopted a lot better than if someone from Infection Control comes in and tells them they have to do things a certain way" (p.22). Similarly, the Patient Safety Plan operates on the premise that front-line staff are untapped resources with the ability to influence peers towards best practice.

Goals & Objectives for Patient Safety

Prioritize opportunities for improvement that have the greatest potential impact on safety, patient care, treatment, and services provided.

Goal # 1: Reduce the likelihood of falls by 5% in 2018.

- o Objectives:

1. Increase accessibility to wheelchairs with anti-tippers and rollers for the Geriatric Unit. This will provide patients with a safer alternative for mobility.
2. Eliminate the use of unsafe and inefficient assistive devices (e.g. rollator walkers) on the Generations Unit.

3. Assessment of Geriatric Unit staffing matrix identify opportunities to provide additional support for current staff.
4. Review and implementation of refined process for initiating Special Precautions upon Intake/Admission.
5. Collaborative initiative with nursing leadership to utilize the Preventing Falls Targeted Solutions Tool, endorsed by The Joint Commission, to achieve significant improvement in all falls and falls with injuries.

Goal # 2: Reduce Medication variances by 5% in 2018

- o Objectives:
 1. Identify and assess medication variances on a monthly basis to maximize patient safety and identify causes of and trends in preventable events that may cause or lead to inappropriate medication use.
 2. Develop an effective relationship with Pharmacy and Nursing to enhance major methods of detecting medication errors.
 3. Promote major methods for detecting medication errors and associated adverse drug-related events such as chart audits, computerized monitoring, direct observation, voluntary reporting, patient monitoring and incident reporting.
 4. A newly appointed Assistant Director of Nursing has been providing direct oversight in appropriate follow-ups and continuing education to operators and witnesses.

Goal # 3: Promote the Culture of Safety

- o Objectives:
 1. Promote compliance with the National Patient Safety Goals.
 2. Improve the dissemination of safety related efforts across the organization readily.
 3. Enhance the Patient Safety Committee transitioning to a more active committee with monthly meetings.

Responsibility

All staff employed or contracted through Seven Hills Hospital are responsible for knowledge of policies and procedures. This plan supports the staff compliance towards established policies and procedures. Staff supervisors work alongside front-line staff to identify deviations from policy, procedures, or standards and promptly resolve errors. In addition, opportunities for enhancing or policies or procedures are identified and routed through the Patient Safety Committee or the Patient Safety Officer.

In a culture of safety, each staff member is a provider of service—the consumer is both the patient and organization. Staff provide services with safety in mind. The organization is provided with an environment rich in safe practices and ultimately benefits all patients and staff receiving best practices.

Sullivan et al. (2011) suggests patient safety to begin with prevention of adverse events. Preventable adverse events are often the result of missing systems, checks and balances, or failure to comply with existing systems designed to catch and prevent these adverse events as demonstrated in Figure 1. Staff work together to promote safety awareness across the organization and influence policy and procedures through supporting resiliency and risk reduction efforts.

Hazards

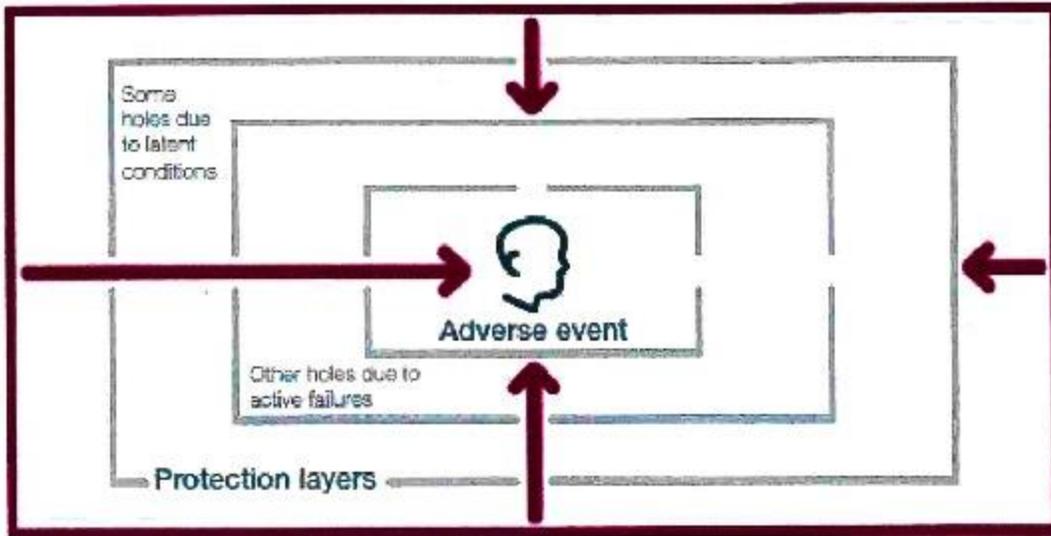


Figure 1. Active failures and latent conditions cause adverse events. Based on the "swiss cheese" model by J. Reason.

Patient Safety Committee

The Patient Safety Committee consists of a Physician, a member of the Executive Staff, the Director of Performance Improvement and Risk Management/Patient Safety Officer, Infection Control Officer, Pharmacist, and front-line staff. Data is received, analyzed, processes and problems identified, and prioritized depending on the urgency of needed interventions. Problems deemed outside the scope of the Patient Safety committee will be sent to other committees for collaboration or referrals.

The Infection Control Officer reports to the Patient Safety Committee and works alongside to reduce or eliminate threats to patient care involving organisms. See Infection Control Plan.

Agency for Healthcare Research and Quality. (2008). Patient safety culture surveys. Retrieved from www.ahrq.gov/qual/patientsafetyculture

Institute for Healthcare Improvement. (2007). *5 million lives campaign how-to guide: Governance leadership*. Cambridge, MA: Author.

Patterson, P. (2011). Looking to front-line clinicians, staff for lasting improvements. *OR Manager*, 27(5), 22.

Sullivan, M., Robertson, G., & Nibbelink, S. (2011). *How an intelligent infrastructure can help optimize hospital safety and security*. North Andover, MA: Schneider Electronic.

World Health Organization. (2012). 10 facts on patient safety. Retrieved from www.who.int/features/factfiles/patient_safety/patient_safety_facts/en

Section 6 Patient Safety		Stonecreek Surgery Center	
Policy Name: PATIENT SAFETY PROGRAM		Page 1 of 7	
Approved:		Revised:	

POLICY:

Stonecreek Surgery Center will institute and administer a comprehensive and continuous Patient Safety Program for all patients to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition of risks to patient safety and medical/health care errors
- Actions to reduce these risks
- Internal reporting of incidents and potential incidents and actions taken
- Focus on processes and systems rather than individual blame

PURPOSE:

The Patient Safety Program provides a systematic, coordinated and continuous approach to maintenance and improvement of patient safety by using established mechanisms to support responses to actual occurrences, have an ongoing proactive plan to reduce medical/health errors, and integrate patient safety as a high priority in all relevant organizational processes and services.

RESPONSIBILITY:

As with patient care, it is a coordinated and collaborative effort of the entire organization to maintain and improve patient safety. The Governing Body approves the data-driven Patient Safety Program and ensures the program reflects the complexity of the facility's organization and services, including those services furnished under contract or arrangement and focuses on the prevention and reduction of medical/health errors and adverse effects. The Director of Nursing is responsible for the management of the Patient Safety Program

by:

- Coordinating all patient safety activities
- Facilitating assessment and appropriate responses to reportable events
- Monitoring Root Cause Analysis and resulting action plans

Section 6 Patient Safety	Stonecreek Surgery Center
Policy Name: PATIENT SAFETY PROGRAM	Page 2 of 7

- Serving as a liaison among the departments to assure facility wide integration of the Patient Safety Program.

Each individual employee within the organization acts as a patient advocate for safety and is responsible to report patient safety occurrences and potential occurrences to the QAPI Coordinator and the Director of Nursing, who will aggregate the occurrence information and report to the Governing Body.

PROGRAM:

The scope of the Patient Safety Program includes an ongoing assessment to prevent error occurrence, maintain and improve patient safety.

Patient Safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed to prioritize organizational patient safety efforts.

Types Of Patient Safety Or Medical/Health Care Errors:

- No Harm Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
- Mild-Moderate Adverse Outcome Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

- Perform necessary healthcare interventions to protect and support the patient's clinical condition.
 - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of contaminated IV fluids from supply should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
- Upon identification of a medical/health care error, the patient care provider will immediately:

What To Do When A Patient Safety Error Occurs

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one of the following (even if the outcome was not death or major permanent loss of function):
 - Suicide of a patient.
 - The sexual assault of a patient during treatment or while the patient was on the premises of the facility.
 - A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
 - Medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient.
 - A surgical procedure on the wrong patient or on the wrong body part of a patient.
 - A foreign object accidentally left in a patient during a procedure.
 - A patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
 - Near Miss – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

Section 6 Patient Safety	Stonecreek Surgery Center
Policy Name: PATIENT SAFETY PROGRAM	
Page 3 of 7	

Section 6 Patient Safety	Stonecreek Surgery Center
Policy Name: PATIENT SAFETY PROGRAM	Page 4 of 7

- Preserve any information related to the error (including physical information).
Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, piggyback fluid for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
- Report the medical/health care error to the staff member's immediate supervisor.
- Submit the incident occurrence report to the QAPI Committee per organizational policy.

Internal Reporting Of The Error/Event

Staff response to medical/health care errors is dependent upon the type of error identified:

- **No Harm Errors** – (including “no harm medication errors), staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident occurrence report form, submit the form to the QAPI Committee and notify their immediate supervisor.
- **Mild-Moderate Adverse Outcome Errors** (including medication errors), staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts in the medical record and on an incident occurrence report, submitting the report to the QAPI Committee per policy.
- **Adverse Drug Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts appropriately in the medical record and on an incident occurrence report, submitting the report to QAPI Committee per organizational policy.
- **Transfusion Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary orders. Staff will then follow the organization policy and procedure for this event.

- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify their supervisor and document the findings on an incident occurrence report which is then submitted to QAPI Committee

- **Sentinel Event** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure, which includes a root cause analysis and action plan.
- **Near Miss** – staff will report the near miss event to their immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to QAPI Committee.

- It is the intent of this facility to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to, their employment. This organization supports the concept that errors occur due to breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the individual staff member's supervisor determining the appropriate course of action to prevent error recurrence.

Root Cause Analysis

- All sentinel events and near miss occurrences will have a root cause analysis conducted to examine the cause and effect of the event through an impartial process
- A Root Cause Analysis is an interdisciplinary review process for identifying the basic or contributing causal factors that underlie a variation in performance associated with an adverse event or reportable patient safety event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.

- The QAPI Committee is responsible for conducting the root cause analysis. It will be completed within 45 days of becoming aware of one of the reportable events. They will encourage the staff members' involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution.

Section 6 Patient Safety	Stonecreek Surgery Center
Policy Name: PATIENT SAFETY PROGRAM	Page 6 of 7

A written Root Cause Analysis and "Action Plan" will be created which includes specific measures to correctly identify problems or areas of concern, identify strategies for implementing system improvements; and also includes outcome measures to indicate the effectiveness of system improvements in reducing, controlling or eliminating identified problem areas. The action plan must specifically address responsibility for implementation and oversight, time frames for implementation, and the strategy for measuring the effectiveness of the actions.

- The Joint Commission recommended "A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event" format may be used. See attached.
- Results of the entire Root Cause Analysis will be presented to the Governing Body for evaluation.

Communication of Action Plans and Root Cause Analysis

- Action Plans related to a Root Cause Analysis will be shared with the entire staff upon completion by the QAPI Committee. Possible recommendations to update or change policy and procedures may be presented to the staff, management and Governing Body to improve patient safety.

- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. There will be a random record review verifying compliance with this educational process.

- Root Cause Analysis and Action Plans will be made available to the state health department representatives during onsite reviews.

Reporting Obligations

- Medical/Health care errors and occurrences, including sentinel events, will be reported internally and externally, through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

Patient Safety Program Staff Education/Training

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

- Medical errors results from multiple factors. Flawed systems or processed can combine with active failures by caregivers in the clinical setting to produce accidents and errors. Some contributing factors are:
 - Inadequate communication among team members
 - Incomplete review of patient health records and diagnostic studies
 - Traditional hierarchical and autocratic cultures
 - Patient – related decisions made only by physicians
 - Unclear instructions
 - Confusing packaging of medications and supplies
 - Time pressures and constraints, Multi-tasking
 - Failure to include the patient and family members in assessment and decision-making
- Staff will be trained about error reduction, which requires the commitment of all members of the health care team. Besides correcting the identified factors above, the following individual and facility changes will be focused on:
 - Reduce reliance on memory by using checklists and protocols.
 - Standardize processes as much as possible for procedures and other activities.
 - Focus on the safety aspects of products during the selection and evaluation process.
 - Promote safety related clinical competency.
 - Educate employees about the potential for errors and how to avoid them.
 - Creating a “Culture of Safety” whereby there is a change of environment from blaming individuals for errors to one in which errors are treated as opportunities to improve systems. This is accomplished by:
 - establishing a sense of trust among team members;
 - dissemination and verifying receipt of information to all levels of staff and management;
 - developing and supporting a proactive approach rather than a reactive approach;
 - making a sincere commitment to affirming safety as the first priority.
- Quarterly Patient Safety Program meetings will be incorporated into the QAPI Program and conducted to review any incident occurrence reports and review any new patient safety recommendations or alerts.

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
What happened?	Sentinel Event	What are the details of the event? (Brief Description)				
		When did the event occur? (Date, day of week, time)				
		What area/service was impacted?				
Why did it happen?	The process or activity in which the event occurred.	What were the steps in the process, as designed? (A flow diagram may be helpful here)				
		What steps were involved in (contributed to) the event?				
	Human factors	What human factors were relevant to the outcome?				
	Equipment factors	How did the equipment performance affect the outcome?				
What were the proximate factors? (typically "special cause" variation)	Controllable environmental factors	What factors directly affected the outcome?				
	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influences this outcome? What other areas of services are impacted?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Page 2 of 5

The following template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for “root cause” and risk reduction.

As an aid to avoiding “loose ends” the three columns on the right are provided to be checked off for later reference.

- **“Root Cause?”** - should be answered “yes” or “no” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that if relevant to the event is not a root cause, be sure that is addressed later in the analysis with a “why?” question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- **“Ask Why?”** - should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn’t occur when it should have (in other words, to drill down further). Each item checked in this column should be addressed in the analysis with a “Why?” question. If it is expected that any significant finding that are not identified as root causes themselves have “roots.”
- **“Take Action?”** - should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write down the number of the associated Action item on page 3 in the “Take Action?” column for each of the findings that requires action.

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
What happened? Why did that happen? What systems and processes underlie those proximate factors? (common cause variation here may lead to special cause variation in dependent processes)	Human Resources Issues.	To what degree is staff properly qualified and currently competent for their responsibilities?				
		How did actual staffing compare with ideal levels?				
		What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?				
		To what degree is staff performance in the operating process (es) addressed?				
		How can orientation and in-service training be improved?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
Information management issues.	Environmental management issues.	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?				
		To what degree is communication among participants adequate?				
Leadership issues: -corporate culture	-encouragement communication	To what degree was the physical environment appropriate for the processes being carried out?				
		What systems are in place to identify environmental risks?				
- clear communication of priorities	- uncontrollable factors	What emergency and failure-mode responses have been planned and tested?				
		To what degree is the culture conducive to risk identification and reduction?				
		What are the barriers to communication of potential risk factors?				
		To what degree is the prevention of adverse outcome communicated as a high priority?				
		What can be done to protect against the effects of these uncontrollable factors?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Action Plan	Risk Reduction Strategies	Measures of Effectiveness
<p>For each of the findings identified in the analysis as reading an action, indicate the planned action expected, implementation data and associated measure of effectiveness OR</p> <p>-If after consideration of such a finding a description is made not to implement as associated risk reduction strategy, indicate the rationale for not taking action at this time.</p> <p>-Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.</p> <p>-Consider whether pilot testing of a planned improvement should be conducted.</p> <p>-Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.</p>	ACTION ITEM #1	
	ACTION ITEM #2	
	ACTION ITEM #3	
	ACTION ITEM #4	
	ACTION ITEM #5	
	ACTION ITEM #6	
	ACTION ITEM #7	
	ACTION ITEM #8	
<p>Cite any books or journal articles that were considered in developing this analysis and action plans:</p>		

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

SUBJECT: QA	POLICY: RISK MANAGEMENT/ PATIENT SAFETY PROGRAM
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE 1 OF 10
	EFFECTIVE:
	REVISED: JANUARY 3, 2016

I. PURPOSE:

Attention to maintaining and improving patient safety and well being is inherent in Ambulatory Surgical Center of Southern Nevada's (ASC of Southern Nevada) commitment to the relief of suffering and improvement in the quality of life to those in the community it serves. In committing ourselves to safeguarding individuals, ASC of Southern Nevada must fully understand the processes and systems that are utilized by the organization to deliver patient care. From this deeper understanding, ASC of Southern Nevada will be able to analyze, evaluate, develop and implement changes that will continuously improve the way we deliver care to patients.

The results of these efforts will:

- Demonstrate ASC of Southern Nevada's commitment to the community it serves.
- Unite ASC of Southern Nevada and individuals who work and practice at ASC to respond appropriately to adverse events, proactively identify risk reduction strategies and participate in process and system redesigns to reduce risk of patient harm.
- Allow ASC to implement processes technology or systems that will reduce the risk of errors reaching patients and causing harm.
- Promote greater medical staff and employee involvement in improving clinical care which will result in improved employee and medical staff satisfaction.
- Translate into a more efficient and cost-effective model of care at ASC.

Ambulatory Surgical Center of Southern Nevada's leadership and employees must actively embrace and support the patient safety plan in order to achieve the results outlined above.

II. SCOPE:

The Ambulatory Surgical Center of Southern Nevada Patient Safety Plan is an all-inclusive, integrated method to planning, designing, measuring, assessing and improving patient safety, quality care and outcomes. Assessing day to day operations, employee input and customer needs are integrated into the development of the program. This program will incorporate all patient related activities and use interdisciplinary teams whenever possible.

Important aspects of patient care and service that involves the monitoring of activities and making improvements include:

- Complications of anesthesia
- Post procedure bleeding
- Post procedure infection
- Medication errors/Look alike sound alike medications

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

SUBJECT: QA	POLICY: RISK MANAGEMENT/ PATIENT SAFETY PROGRAM
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE 2 OF 10
	EFFECTIVE:
	REVISED: JANUARY 3, 2016

- Allergic reaction
- Medical Equipment related adverse event
- Technical difficulty with procedure
- Proper indication
- Proper consent
- Current H & P
- Risk Stratification
- Anticoagulation Problems
- Patient Satisfaction
- Pathology Specimen errors
- Time outs
- Patient Education/discharge instructions
- Day of Procedure Cancellations
- Identity Theft/Lack of ID
- Reprocessing errors
- Non-compliant patients with pre-procedure instructions
- Communication with referring providers
- Sentinel Events
- Medical Records Documentation
- Scheduling errors
- Infection Control Survey Rounds
- Help patients to be involved in their care.
- Medication reconciliation
- Improve staff communication
- Hand hygiene
- Prevent patient from falls
- Responsible adult to accompany patient home
- Patient Identification
- Single use of injection devices
- Fire Prevention and Safety in the Procedure Rooms

The Ambulatory Surgical Center of Southern Nevada recognizes that risk management and patient safety are priorities that include establishing, maintaining and improving the safety of patients and the facility.

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

SUBJECT: QA	POLICY: RISK MANAGEMENT/ PATIENT SAFETY PROGRAM
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE 3 OF 10
	EFFECTIVE:
	REVISED: JANUARY 3, 2016

III. STRUCTURE:

Governing Body

The Governing Body of the Ambulatory Surgical Center of Southern Nevada (ASC of Southern Nevada) is comprised of members including: ASC principal owners, Administrator and Medical Director. The Governing Body assumes full legal responsibility for determining, implementing and monitoring policies so as to provide quality health care in a safe environment and to protect the health and safety of patients and employees. When services are provided through a contract with an outside resource, the Ambulatory Surgical Center of Southern Nevada (ASC of Southern Nevada) will, to the best of its ability, assure that these services are provided in a safe and effective manner. The Governing Body will carry out the following duties and responsibilities either directly or by delegation to committee(s).

The Governing Body oversees this responsibility by:

- Ensuring each patient admitted to the facility is under the care of a physician.
- Ensuring each patient admitted to the facility has had a pre-surgical exam within seven days prior to the date of the procedure.
- Ensuring that a physician is on the premises and is immediately available at all times while patients are in procedure rooms or in the recovery area.
- Maintaining an adequate number of qualified and competent staff to meet the needs of the patients.
- Oversight and accountability for developing a program of quality improvement and risk management appropriate to the specific needs of ASC of Southern Nevada that follow all federal, state and third party regulatory requirements.
- Ensuring that the facility policies and procedures are administered in such a manner that provides health care in a safe environment.

Medical Director

The Medical Director who also serves as the Patient Safety Officer represents the ASC and the medical staff in decision-making processes through direct participation and/or formal referral recommendations. The Medical Director is responsible for determinations as to needed resources when providing services relating to patient care.

The duties of the Medical Director include:

- Oversee and actively participate in the Quality Assurance/Risk Management activities.
- Oversee and actively participate in the Patient Safety Committee
- Participate in the development and have final approval on all service specific policies and procedures associated with patient care.
- Responsible for providing continuing educational in-services for the facility and medical staff in regards to patient care when necessary.
- Active role in evaluating and identifying staffing needs.

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

SUBJECT: QA	POLICY: RISK MANAGEMENT/ PATIENT SAFETY PROGRAM
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE 4 OF 10
	EFFECTIVE:
	REVISED: JANUARY 3, 2016

Risk Management/Patient Safety Officer

The Patient Safety Officer will have primary oversight of the facility-wide patient safety program. The Patient Safety Officer will direct others within the facility towards process improvements that will support the reduction of medical/health care errors and other factors that contribute to unexpected adverse patient outcomes.

The duties of the Patient Safety Officer include:

- Notify the liability insurance carrier when adverse or reportable events occur.
- Coordinates the activities of the Patient Safety Committee.
- Investigate patient safety issues, along with the patient safety committee, within the facility.
- Recommend and facilitate change within the organization to improve patient safety based on identified risks.
- Serve as a resource on issues of patient safety.
- Support and encourage error reporting throughout the facility through a non-punitive error reporting system.
- Take such action as he/she determines necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the Governing Body on the occurrence of known medical and health care errors and identified near misses and dangerous conditions within the facility.

Patient Safety Committee

Patient Safety Committee is a part of the Quality Assessment Performance Improvement Committee and is comprised of the Medical Director, Administrator/ Patient Safety Officer,, Director of Nursing and the charge. The Patient Safety Committee/Quality Assessment Performance Improvement Committee is responsible to the Governing Body and Administration for the overall operation of the Risk Management and Patient Safety Plan. The Patient Safety Committee meets on a quarterly basis or as needed. Patient Safety Goals will be developed on a yearly basis.

The duties of the Patient Safety Committee include:

- Reviewing and evaluating the quality of patient safety measures.
- Review all adverse outcomes.
- Review incidents
- Making recommendations to eliminate future serious events or incidents.
- Reporting to the Governing Body on a quarterly basis to include the occurrence of medical/health care errors and actions taken to improve patient safety.

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

SUBJECT: QA	POLICY: RISK MANAGEMENT/ PATIENT SAFETY PROGRAM
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE 5 OF 10
	EFFECTIVE:
	REVISED: JANUARY 3, 2016

- Make recommendations to the Governing Body to reduce the number and severity of sentinel events that occur at the facility.
- Assess the quality indicators that affect patient safety and patient health outcomes.
- Coordinate the collection of data from the quality indicators where needed, perform QI studies and improve our patient care processes.

IV. Definitions

Incident - any occurrence that is not consistent with the routine care or operation of the organization. Incidents may involve patients, visitors, employees and medical staff members (i.e. patient fall, employee injury, etc.).

Adverse Incident/Sentinel event – Is defined as an unexpected occurrence during a healthcare visit involving, death or serious physical or psychological injury or the risk thereof, including, loss of limb or function, not related to the natural course of the patient’s illness or underlying condition (AAAHC/Nevada Revised Statutes).

Root Cause Analysis – Is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special causes in clinical processes to common causes, in organizational processes and systems and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis, that no such improvement opportunities exist. [Joint Commission on Accreditation of Healthcare Organizations]

Action Plan – The product of the root cause analysis is an action plan that identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions. [Joint Commission on Accreditation of Healthcare Organizations]

Near Miss – any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome. [Joint Commission on Accreditation of Healthcare Organizations] It is an event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or by timely intervention. Near misses are opportunities. Examples of near miss that would require the use of an incident form include but are not limited to:

- Equipment Reprocessing errors not used on patients.

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

SUBJECT: QA	POLICY: RISK MANAGEMENT/ PATIENT SAFETY PROGRAM
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE 6 OF 10
	EFFECTIVE:
	REVISED: JANUARY 3, 2016

V. Reporting Mechanisms

To effectively reduce adverse patient outcomes, there must be an environment that supports employees by identifying and learning from errors and system failures. Ambulatory Surgical Center of Southern Nevada (ASC) encourages all employees to report any errors or work methods that may lead to potential adverse patient outcomes. The ASC supports a non-punitive, open communication culture.

A. *Non-Punitive Reporting*

The facility recognizes that if we are to create a safe environment for our patients and visitors, we must create an environment that is safe for caregivers to report and learn from events and near misses. The facility requires that employees report errors and encourages them to do so.

1. The goal is to identify and track errors in order to continuously improve our systems and to provide the necessary education to prevent reoccurrence.
2. All events, especially those of a clinical nature need to be reported immediately. It is expected that complete disclosure shall occur. Reporting will be in confidence and shall not suffer harassment or retaliation.
3. An employee who knowingly fails to report a clinical error will be subject to disciplinary action.

B. *Adverse Event/Incident/Complication/Infection Tracking System*

1. All information regarding Complications and Adverse events is collected and documented in the Incident Tracking Report and the Adverse Reactions and Complications Report.
2. The data reviewed that is not consistent with the normal operations of the facility or the anticipated disease/treatment process of the patient is communicated to the Medical Director and or Administrator.
3. The facility's processes will be reviewed to determine methods to prevent reoccurrence, improve quality care and ensure patient and visitor safety.

C. *Sentinel Events*

When a sentinel event occurs, appropriate individuals are notified and immediate attention investigation is undertaken. The sentinel event policy describes the reporting structure and responsibilities of the designated individuals. A root cause analysis and action plan may be implemented if necessary.

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

SUBJECT: QA	POLICY: RISK MANAGEMENT/ PATIENT SAFETY PROGRAM
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE 7 OF 10
	EFFECTIVE:
	REVISED: JANUARY 3, 2016

D. Patient Complaint/Grievance

Complaints can be reported to the Director of Nursing, Administrator or Medical Director. Employees should report all complaints immediately to their supervisor. Patients should notify the Director of Nursing. All complaints will be investigated and a response or corrective action will be made.

VI. Communicating With Patients About Safety

1. Patients Rights and Responsibilities, Advance Directive, Complaint and Grievance Process and Physician Ownership Disclosure shall be explained to the patient at the time the procedure is scheduled via the written copy provided to them.
2. Patients are also provided instructions prior to their procedure.
3. Patient education is provided on safe use of medication regarding their procedure.
4. The day of procedure, the nurse reviews the procedure with the patient and what is involved in the pre and post op care.
5. The nurse verifies the allergies with the patient and medications' confirming that the patient has withheld the anticoagulants, anti-inflammatory and aspirin as ordered by the physician.
6. Verify procedure with patient.
7. Encourage patient to ask questions.
8. If there is a language barrier provide interpretation.
9. Use side rails once patient is in gurney to prevent falls.
10. Make sure the patient uses the call light to ambulate off gurney.
11. Involve patients in Time Outs in procedure room before start of case.
12. Review post-op instructions with patient or family member and verify that the patient understands his/her instructions.
13. Confirm that the patient has an adult to drive them home and does not operate vehicle post procedure if sedation was administered.
14. Confirm that follow-up appointment is communicated with patient if needed.
15. Provide educational pamphlets on diagnosed conditions for patient education.

VII. Staff Education

1. Initial and annual training is provided to all employees on safety in the work environment.
2. Risk Management, Infection Control, Hand Hygiene, Blood Borne Pathogens, Personal Protective Equipment and Safe Injection Practices Training is provided to staff.
3. Educating and following the Time Out Policy to assure that we have the right patient and

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

SUBJECT: QA	POLICY: RISK MANAGEMENT/ PATIENT SAFETY PROGRAM
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE 8 OF 10
	EFFECTIVE:
	REVISED: JANUARY 3, 2016

and the right procedure.

4. Importance of verifying color of arm band for the correct patient, correct procedure.
5. Staff meetings are held to communicate quality improvement and patient safety issues.
6. Ongoing education to staff is provided regarding patient safety issues.
7. Staff education on all disinfectants used throughout the facility.
8. Patient safety checkpoints are added to the pre, intra and post documentation.

VIII. Safety Improvement Activities/Methodologies

Medication/Pharmacy Surveillance – All matters pertaining to the use of drugs in the Center will be monitored on a monthly basis by a contracted pharmacist. See service Contracts for facility.

High Alert Medications – All employees or providers that handle patient medication will follow the procedure for the safe storage and handling of high alert medications. See High Alert Medication Policy.

Infection Surveillance – Infection surveillance will be completed by the Director of Nursing, or his/her designee, on a monthly basis or as needed and the findings reviewed with the Patient

Safety Committee and staff. Identifying processes that can cause potential risk to patient and visitor safety will be addressed. Recommendations will be communicated to staff members on any new measures to be implemented to ensure patient and visitor safety.

Facility Safety Surveillance – Facility safety surveillance will be done on a monthly basis by a designated employee or as needed to ensure there are no hazardous conditions that would be a safety concern for patients, visitors or employees.

Follow-up Phone Calls to Patients – All patients are called post procedure to document any Complications they may be having or questions they may have.

Patient Satisfaction Survey – Patient Satisfaction surveys are completed on a random number of patients on a monthly basis. The results are communicated to the employees Physicians and the Administrator which function collaboratively to achieve positive patient outcomes when possible.

Monthly Physician Infection Control Reports – Physicians communicate to the Director of

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

SUBJECT: QA	POLICY: RISK MANAGEMENT/ PATIENT SAFETY PROGRAM
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE 9 OF 10
	EFFECTIVE:
	REVISED: JANUARY 3, 2016

Nursing any patient that may have developed an infection that was not identified on the Follow-up phone call made by the nurse.

High-Level Disinfectant Solution Checks – Before each endoscope is placed in the automated endoscope reprocessor, the minimum effective concentration is checked to ensure that the active ingredient in the solution still passes the manufacturer’s guidelines for reuse before the endoscope is placed in the machine. This is done for each endoscope with all data documented into log books.

Cleaning and Disinfection of Patient Care Equipment – All reusable equipment is classified and processed according to the CDC’s guidelines. Employees clean all reusable equipment to ensure the health and safety of our patients.

Safe Injection Practices – All patient care providers follow safe injection practices to prevent patient to patient transmission of bloodborne pathogens. See Safe Injection Practices policy.

Time Outs – Performed with the anesthesia provider, physician and GI Tech before the start of each procedure to verify right patient, right procedure and allergies.

Hospital Transfers – Any patient transferred to the hospital post procedure will have a peer review process performed to recommend areas of improvement if necessary and quality of care.

Cecal Intubation Rates – All physicians are monitored and reported on a monthly basis. Rates are benchmarked against best practices for colonoscopy completion rate. Effective colonoscopists should be able to intubate the cecum in more than 90% of all cases and in more than 95% when the indication is screening and healthy adult.

Withdrawal Time – All physicians are monitored and reported on a monthly basis. Rates are benchmarked against best practice which is more than or equal to 6 minutes.

Physician Peer Review – All physicians are monitored quarterly. Ten charts are reviewed per physician and anesthesia provider. Results are communicated to the Medical Director.

IX. Annual Review of Patient Safety Plan

The Patient Safety Committee is responsible for the annual review of the Patient Safety Plan. Included in this review the committee will set goals for the new year and focus on

AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA

SUBJECT: QA	POLICY: RISK MANAGEMENT/ PATIENT SAFETY PROGRAM
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE 10 OF 10
	EFFECTIVE:
	REVISED: JANUARY 3, 2016

the patient quality indicators that affect patient safety and patient health outcomes. Quality Indicators will be selected throughout the year and QI studies will be implemented to evaluate our current processes. This effort is undertaken so that processes, functions and services can be designed or redesigned to improve patient services or prevent any health risks to patients.

**NEVADA ENDOSCOPY MANAGEMENT, INC
GASTROENTEROLOGY CONSULTANTS, LTD
RENO ENDOSCOPY CENTER, LLC
SOUTH MEADOWS ENDOSCOPY CENTER, LLC
CARSON ENDOSCOPY CENTER, LLC**

POLICY AND PROCEDURE MANUAL

Policy: Patient Safety Plan
Owner: Center
Date last updated: Revised 4/2016

Purpose: Gastroenterology Consultants, Ltd (GIC) and affiliated Endoscopy Centers are committed to ensuring the ongoing safety of our patients. To ensure the ongoing safety and care of our patients we follow specific guidelines and policies which, at a minimum, include:

I. Infection Control (IC): Refer also to the Infection Control (IC) Policy

1. Guidelines followed include:

- a. American Society for Gastrointestinal Endoscopy (ASGE) Multisociety Guideline on Reprocessing Flexible Gastrointestinal Endoscopes 2011
- b. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes 2015
- c. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Standard of Infection Prevention in the Gastroenterology Setting 2015
- d. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Guideline for Use of High Level Disinfectants and Sterilants for Reprocessing Flexible Gastrointestinal Endoscopes 2013
- e. American Society for Gastrointestinal Endoscopy (ASGE) Infection Control during GI Endoscopy 2008
- f. Center for Disease Control (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007
- g. CDC Guide to Infection Prevention for Outpatient Settings 2014
- h. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the Elimination of Clostridium difficile in Healthcare Settings 2013
- i. CDC Safe Injection Practices

2. The IC Policy includes, at a minimum, processes or guidelines for:

- a. Patient selection and placement within the facility
- b. Infection Control Monitoring and Surveillance, Reporting
- c. Standard and Transmission Precautions, Hand Hygiene, Personal Protective Equipment, Respiratory Hygiene / Cough Etiquette and General Infection Control Practices in Healthcare Facilities as developed by the CDC and APIC
- d. Environmental and Terminal Cleaning
- e. Infection Control Officer

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.117 - 49.123 and NRS 49.265.

- f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

II. Patient Selection and Screening: Refer also to the Criteria for Scheduling Patients at ASC Policy.

1. To ensure patients are appropriate for the planned procedure in the planned setting patients undergo:
 - a. Pre-procedure scheduling evaluation with referral for office visit or consultation as appropriate
 - b. Pre-procedure assessment which includes at a minimum:
 - i. Review of past medical & surgical history
 - ii. Medication reconciliation, review
 - iii. Allergy and reaction, review of
 - iv. Physical assessment; assessment for communicable diseases
 - v. Vital signs

III. Patient Identification: Refer to Patient Identification Policy. Patient identity is verified with at minimum two (2) identifiers at check-in and at multiple points throughout care.

IV. Safe Surgery Checklist: Refer to Safe Surgery Checklist Policy. Patient and procedure are verified immediately prior to procedures.

V. Discharge Teaching: Patients are provided with written discharge instructions which are reviewed with patient and driver, as applicable, prior to discharge. Medications are reconciled prior to discharge if any new medications are ordered. Information specific to diagnosis, as best as known, is given to the patient. Patients are educated about signs and symptoms to report and given a twenty-four (24) hour telephone number to call in event of questions or concerns.

VI. Post Procedure Callbacks: Patients are contacted one (1) to two (2) business days post-procedure for follow up of any concerns and questions regarding discharge instructions.

VII. Pathology follow up: Patients are notified of pathology results and given information and follow up orders as applicable within two (2) weeks.

VIII. Pharmaceutical Services: Refer to Pharmaceutical Services Policy. Safe injection practices are strictly followed. Pharmaceutical services are overseen by a contracting pharmacist on a monthly basis.

IX. Quality Assurance and Benchmarking: Refer to the Quality Management Plan. More than one hundred (100) quality assurance checkpoints are monitored on per patient, per case, per day, per week or per month basis as applicable. Benchmarking of multiple facility and nursing care factors are completed on an ongoing basis. In addition, multiple procedure-related factors are tracked and trended in aggregate and specific to individual

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

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physicians on an ongoing basis. Incidents, procedure complications/events, adverse and sentinel events are investigated tracked and trended by facility, staff and physician. All data is reported to the Quality Management Committee.

- X. Staff Training:** Extensive staff training is done at time of hire. Annual staff retraining is mandatory; ongoing training is provided as applicable. Staff are evaluated for customer service and performance on an ongoing basis.
- XI. Checklists:** All items above are monitored via specific checklists, logs and or chart documentation.

Refer to:

- Infection Control Policy
- Criteria for Scheduling Patients at ASC Policy
- Identification of Patient Policy
- Pharmaceutical Services Policy
- Quality Management Plan
- Safe Surgery Checklist Policy
- Incident Reports Policy
- Complications: Procedure Event, Adverse and Sentinel Events Policy
- Staff Training Competencies and Logs
- NRS 439.865; 439.877

Approved Board of Managers REC/SEC/ CEC 10/11/11; Revised 8/9/12, Approved Board of Managers REC/SEC 1-31-16; CEC 1-25-16; Approved Medical Directors 4/2016

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Section 3 Safety Management	Smoke Ranch Surgery Center
Policy Name: PATIENT SAFETY GOALS	
Page 1 of 3	
Approved: JAN 27 2010	Revised:

The Governing Body of this facility is committed to providing the patients at Smoke Ranch Surgery Center the safest environment within the control of the organization. This facility will incorporate these patient safety goals as a part of the overall Safety Program.

- **Goal 1: Improve the accuracy of patient identification.**
 - Use at least two patient identifiers when providing care, treatment or services, such as medication administration.
 - Eliminate transfusion errors related to patient misidentification.
- **Goal 2: N/A**
- **Goal 3: Improve the safety of using medications.**
 - Label all medications, medication containers and all other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups and basins.
 - Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.
- **Goal 4, 5, 6: N/A**
- **Goal 7: Reduce the risk of health care-associated infections.**
 - Comply with CDC or WHO hand hygiene guidelines.
 - Implement evidence-based practices for preventing surgical site infections.
- **Goal 8: Accurately and completely reconcile medication across the continuum of care.** (Note: all requirements for Goal 8 are not in effect at this time)
 - Obtain an accurate list of the patient's current medications (including OTC and herbal) and known allergies, prior to surgery.
- **Goal 9, 10, 11: N/A**
- **Goal 12, 13: N/A**
- **Goal 14, 15, 16: N/A**

Section 3 Safety Management	Smoke Ranch Surgery Center	
Policy Name: PATIENT SAFETY GOALS		Page 1 of 3
Approved: JAN 27 2010	Revised: FEB 01 2011	

The Governing Body of this facility is committed to providing the patients at Smoke Ranch Surgery Center the safest environment within the control of the organization. This facility will incorporate these patient safety goals as a part of the overall Safety Program.

- Goal 1: **Improve the accuracy of patient identification.**
 - Use at least two patient identifiers when providing care, treatment or services, such as medication administration. Patient identifiers can be the individual's name, date of birth, assigned identification number, telephone number or other person specific identifier.
 - Eliminate transfusion errors related to patient misidentification.
- Goal 2: **N/A**
- Goal 3: **Improve the safety of using medications.**
 - Label all medications, medication containers and all other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups and basins.
 - Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.
 - See also policies in the Anesthesia/Pharmacy manual and the Nursing manual.
- Goal 4, 5, 6: **N/A**
- Goal 7: **Reduce the risk of health care-associated infections.**
 - Comply with CDC or WHO hand hygiene guidelines.
 - Set goals for improving hand hygiene compliance.
 - Implement evidence-based practices for preventing surgical site infections.
 - Conduct Infection Control risk assessments.
- Goal 8: **Medication Reconciliation.** (Note: all requirements for Goal 8 are not in effect at this time. This goal will be updated when it is in effect.)
- Goal 9, 10, 11: **N/A**
- Goal 12, 13: **N/A**
- Goal 14, 15, 16: **N/A**

Section 3 Safety Management	Smoke Ranch Surgery Center
Policy Name: PATIENT SAFETY GOALS	Page 2 of 3

- **Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery**

- Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
- Implement a process to mark the surgical site, and involve the patient in the marking process.
- Conduct a TIME OUT immediately before starting the procedure.

The National Quality Forum's (NQF) new report, *Safe Practices for Better Healthcare*, lists best practices that experts agree would significantly improve patient safety. Some of the practices that will be incorporated in Smoke Ranch Surgery Center's safety plan include, but are not limited to:

- Create a culture of safety by establishing policies on issues such as prioritizing and analyzing patient safety events and training staff in teamwork-based problem solving skills.
- Specify a protocol to ensure that you have adequate nursing care based on your patient mix and nurse experience.
- Record and read back verbal orders to the prescriber immediately.
- Use only abbreviations and doses that the organization has standardized.
- Prepare patient care summaries from original source documents, not from memory.
- Transmit care information, such as order changes or diagnostic information, on time and in an understandable format to all providers who may need the information to care for a patient.
- Ask patients or legal surrogates to repeat what providers explained to them about informed consent.
- Prominently display patient's preferences for life-sustaining treatment in their charts.
- Standardize protocols for preventing wrong-site or wrong-patient procedures by using a pre-surgical checklist and establishing a process to mark the operative site.
- Evaluate preoperative patients for the risk of surgical site infection and implement appropriate preventive measures such as antibiotic prophylaxis.
- Use a hygienic hand rub or wash your hands with disinfectant soap before and after contact with patients or objects immediately around them.
- Keep the medication preparation area clean, orderly, well lit and free of clutter, distraction and noise.
- Use standard methods for labeling, packaging and storing medications.
- Identify all "high-alert" drugs, such as chemotherapy agents, anticoagulants, insulin or narcotics.

Section 3 Safety Management	Smoke Ranch Surgery Center
Policy Name: PATIENT SAFETY IN THE OPERATING ROOM	Page 1 of 4
Approved: JAN 27 2010	Revised:

POLICY:

Patient safety refers to a systematic facility-wide program to minimize preventable physical injuries, accidents and undue psychological stress during the visit. The nursing practice for safety standards is as follows:

- Patient Identification
 - The Operating Room RN always identifies the patient by checking the wristband with the patient's chart and the operating schedule. In addition, the RN verifies the patient identification through verbal communication with the patient and/or caregiver.
- Patient Observation
 - Patients on stretchers or operating tables are never left unattended. Side rails and/or safety straps are utilized.
 - Special care is ensured by provision of an adequate number of personnel when moving patients to and from the operating table or when positioning patients on the operating table. When positioning patients, it is essential to provide supportive devices to protect nerves and blood vessels. Limbs are never to be hyperextended.
- Dedication to Meticulous Aseptic Technique
 - Facility team members must know and apply the principles of aseptic and sterile technique at all times to avoid life-threatening postoperative infection.
- Execution of Accurate Counts
 - The responsibility of accounting for all sponges, instruments, needles and sharps before the surgery begins and at the time of closure rests with the circulating and scrub persons per established policy. The Operating Room RN must document on the operative record the outcome of all final counts. Patients are not to leave the operating room until final counts are correct. If necessary x-ray will be used to determine that the missing item is not located in a patient cavity.

using two patient identifiers, i.e. Name and DOB

- Use of Operating Equipment
 - All equipment and appliances must be set up and used according to the recommendations and instructions of the manufacturer. The biomedical engineer must inspect all new electrical equipment prior to use and every six (6) months thereafter. Electrical equipment must be properly grounded to prevent electric shock and burns.

- Prevention of Burns
 - The scrub person shall immerse all hot instruments in a basin of cool sterile water prior to handing them to the surgeon.
 - Proper placement of the electrosurgical ground pad is essential to prevent electrical burns. Cautery devices, when not in use, are to be secured in a holster. Coagulation/cutting settings on the electrosurgical units are set at the lowest setting and gradually increased.
 - Flammable solutions (i.e., alcohol) are not to be utilized when electrosurgery is in progress.
 - All electrical equipment must be inspected prior to use.

- Administration of Drugs
 - All drugs used by the surgeon are documented in the operative record. The Operating Room RN and the scrub person identify all drugs transferred to the sterile field.
 - The scrub person repeats the name and dosage of the drug when transferring it to the surgeon.
 - If more than one drug is present on the sterile field, each drug must be correctly identified.

- Preparation of Specimens
 - All tissue removed from a patient, unless exempt, is sent to the pathology laboratory and labeled with the site of the specimen.

- *It is the responsibility of the scrub person to communicate to the Operating Room RN the origin of each specimen. It is the responsibility of the Operating Room RN to label and record each specimen accurately.*
- All specimens for frozen section are placed in a dry container and forwarded to the pathology laboratory. **NOTE:** Frozen section specimens are delivered to the pathology laboratory by a special courier. The courier signs the specimen log denoting delivery of the frozen section specimen.
- Fire Safety
 - Response of the facility team to a fire is outlined in the Safety Manual. Facility personnel participate in the quarterly drills as appropriate and review fire precautions annually.
- Emergency Management Responses
 - Response of the facility team in a disaster situation is outlined in the Comprehensive Emergency Management Plan. Facility personnel participate in regularly scheduled disaster drills and inservice education.
- Radiation Safety
 - X-ray badges are issued quarterly to all scrub persons and Operating Room RNs and are to be worn at all times in the operating suite. Badges are forwarded to the radiation detection company. Dosimetry reports are reviewed by the Clinical Director for current and cumulative dose per employee. These reports are filed in the facility.
 - Radiation barrier gloves are available for use whenever there is a potential for radiation exposure to hands.
- Equipment Maintenance
 - All operating room equipment is inspected for operational integrity by facility personnel prior to each use and on a monthly basis. Equipment is to be removed from service immediately if needed repair or a malfunction is evident. A repair tag is attached indicating the name of the department and the source of the malfunction.

- Disposal of Waste
 - All infectious (biohazardous) wastes, including glass, are single red-bagged, placed in a special collection container marked "Biohazardous Waste" and disposed of appropriately.
- Disposal of Needles and Syringes
 - Used needles and syringes are placed in rigid sharps disposal container, which are located throughout the facility. When container is 3/4 full, it is disposed of with the biohazardous waste and replaced with a new sharps disposal container.
- Use of Extension Cords
 - Under normal conditions, extension cords shall not be used. Temporary use of extension cords may be permitted under specified conditions and with the proper approval.
 - Power failure: Extension cords may be used to connect items to limited charged power outlets.
 - Extension cords will be 16 AWG or heavier.
- Use of Adapters
 - Adaptor use within the facility is prohibited.
- Anesthesia Safety
 - Only nonflammable anesthetic agents are utilized in the operating rooms.
 - Refer to Anesthesia Policy and Procedure Manual for other anesthetic safety standards.

Please revise and expand this template to meet your facility's needs.

CORONADO SURGERY CENTER
Facility Name:

DATE:



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

Coronado Surgery Center
Facility Name:

~~This plan was created and revised by the (facility name) Patient Safety committee/team.
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encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety,
as well as reduce the medical/healthcare errors and /or preventable events.~~

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Patient Safety Committee/Program
Coronado Surgery Center~~Facility name:~~
2779 W. Horizon Ridge Parkway Suite 140 Facility Address
P 702-589-9250 F 702-589-9257 Facility contact information

Contents

Commitment to Patient Safety.....	3
Mission, Vision, and Values	3
Scope and Purpose.....	3
Roles and Responsibilities.....	4
Roles and Responsibilities	5
Objectives and Goals of the Quality and Patient Safety Plan	8
Components and Methods	8
Root Cause Analysis.....	9
Model for Improvement.....	10
Data Collection and Reporting.....	12
Assessment of the Quality and Patient Safety Plan	13
Patient Safety Checklists and Patient Safety Policies	13
Approval of Patient Safety Plan.....	15
Reference.....	15
Appendix A: Terms and Definitions	16
Appendix B: Patient Safety Goals	19
Appendix C: Fishbone Diagram.....	Error! Bookmark not defined.
Appendix D-1: PDSA Worksheet.....	19
Appendix D-2: PDSA Monthly / Quarterly Progress Report	21
Appendix E: Checklist Example: Injuries from Falls and Immobility.....	22
Appendix F: Policy Example	23

Commitment to Patient Safety

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

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Mission, Vision, and Values

In support of our mission, vision, and values, Coronado Surgery Center (facility name's) Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in Coronado Surgery Center (facility name) are required to fully support and participate in this plan and devote their expertise to the patient safety and healthcare quality improvement process.

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

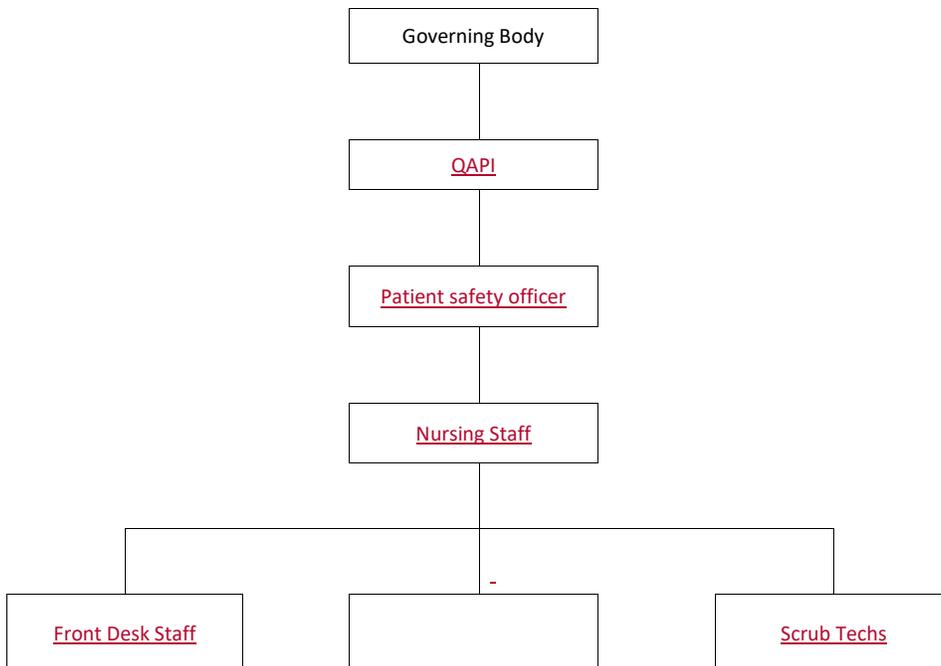
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

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

Roles and Responsibilities

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

The Patient Safety Committee Organization



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Roles and Responsibilities

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

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

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

The roles and responsibilities are defined below (Please modify them as needed.)

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

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

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

Root Cause Analysis (RCA) Team Responsibilities *(please revise as needed)*

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities *(based on NRS 439.870)*

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

(Additional responsibilities here if needed)

Infection Control Officer Responsibilities *(based on NRS 439.873)*

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

(Additional responsibilities here if needed)

RCA team leader Responsibilities *(please revise as needed)*

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.

- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Collect Data
- Reconstruct event
- Record review
- Interview Staff
- Identify how/why event occurred
- Expose actions that led to event to prevent future harm
- Use swiss cheese model

~~(Please provide the responsibilities here)~~

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Executive or Governing Body Staff Responsibilities ~~(please revise as needed)~~

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

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~~(Please provide additional responsibilities here if needed)~~

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

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan

- Identifying the Plan-Do-Study-Act (PDSA) topics.
- Discussing corrective action process and activities.
- Discussing and presenting possible changes in procedure to improve areas indicated.
- Identifying strengths and areas that need improvement.
- Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

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Quality Guiding Principles

1. Focus on Quality and Patient Safety – it is everyone's responsibility
2. Improve all that is undertaken
3. Provide service excellence to our customers
4. Align Mission, Vision, and Strategy
5. Ensure continuous improvement that is process-focused, data-driven, and measures results
6. Foster creativity and innovation in an environment that values and encourages employee participation
7. Practice teamwork and collaboration, recognizing the unique and valuable contribution each member makes to the team
8. Ensure the program is a continuing one, not just a one-time effort
9. Ensure the program identifies in a systematic manner what data will be collected to measure various aspects of quality of care, the frequency of data collection, and how the data will be collected and analyzed.
10. Ensure the data collected is used to assess quality and stimulate performance improvement.

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Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the

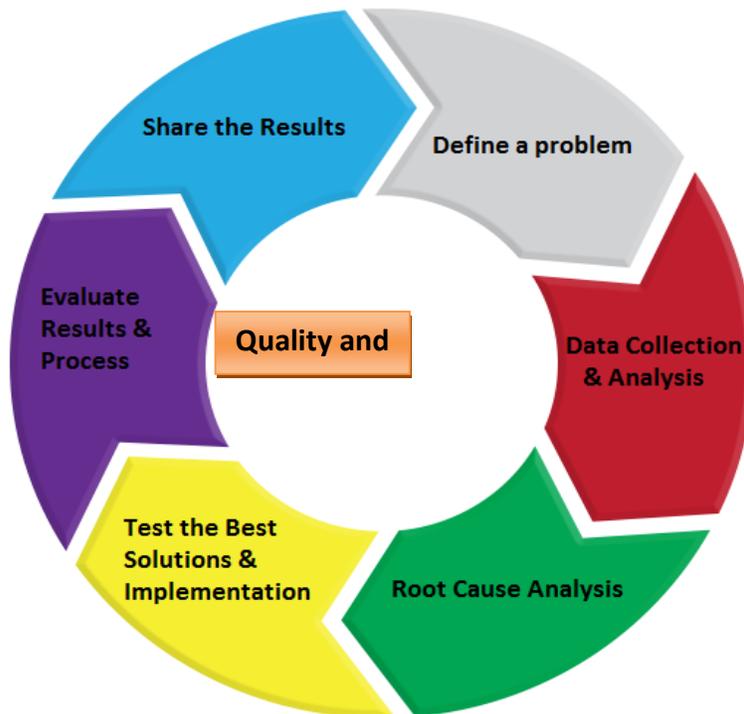
Patient Safety and Quality Improvement Plan

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sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

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

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Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the

questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used ~~at Coronado Surgery Center to (facility name)~~ to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

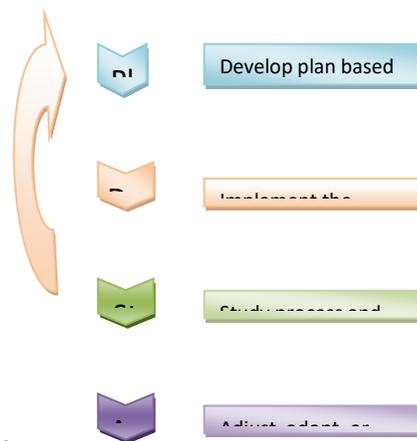
Fishbone Diagram

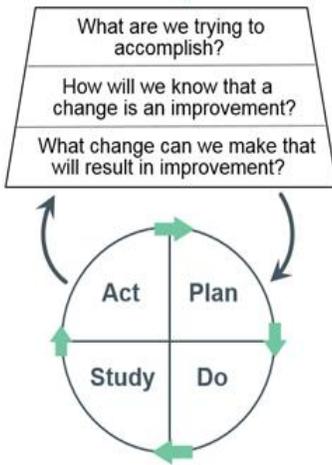
Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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





The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Coronado Surgery Center ~~(Facility name)~~ is using ~~(data system name Redcaps)~~ for tracking the sentinel events, healthcare infection data, and ~~variance (any other database) for reports for~~ internal data collection.

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

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



Ongoing Reporting and Review

Data points such as the following will be reviewed ~~according to per~~ the schedule prescribed:

Monthly	Quarterly	Annually
---------	-----------	----------

1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising
--	--	--

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

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

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

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

The patient safety checklists are listed in Appendix E. ~~(The following links provide some patient safety checklists for your reference—a checklist example is shown in Appendix E.)~~

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html

- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools.
	b. Establish an automated surveillance process.			Develop automated surveillance reports in Cerner.
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS.	
	b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.		Increase number of events reported by 10%.	
	c. Establish a process for providing feedback regarding reported events.		Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.	
	b. Establish a recognition program that rewards safe practices.		Include patient safety presentation in monthly New Employee Orientation.	
	c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
	b. Facilitate the development of action plans associated with measures not meeting benchmarks.	Complete 2014 Leapfrog Safety Survey.	Establish & implement a plan to improve performance of each leap.	
	c. Assess and improve processes related to hand-off, transition and communication	Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.		Establish Patient Safety Council.	
	b. Reduce and eliminate variation in care.		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:	
Person Completing Worksheet:	Date:

Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			
3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

--

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.
--	--

--	--

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
--	---

- Adapt: modify changes and repeat PDSA Cycle
- Adopt: expanding changes throughout organization
- Abandon: change approach and repeat PDSA cycle

Appendix D-2: PDSA ~~Monthly~~ Quarterly Progress Report

Event:

Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
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Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition	-	-	-	-
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)	-	-	-	-
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds	-	-	-	-
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, when applicable, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

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Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies, MERCY Hospital, <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

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 MERCY HOSPITAL	HOSPITAL POLICY AND INFORMATION MANUAL		
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2	Date Issued:- Date Last Revised:- Next Review Date:- Approved By:-	07/01-08/14- 08/17- Policy Committee-	Key Words:- pers

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~~onal protective equipment, PPE, safety equipment,-~~

Policy Applies to:-

- ~~• All staff employed by Mercy Hospital;-~~
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- ~~• EQUIP5 – 1.5.1 and 1.5.2 Infection Control-~~
- ~~• EQUIP5 – Standard 3.2 Criterion 3.2.1 Health and Safety-~~

Rationale:

Coronado Surgery Center ~~Mercy Hospital~~ will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

<u>Coronado Surgery Center</u> 	HOSPITAL -POLICY AND INFORMATION MANUAL		
PERSONAL PROTECTIVE EQUIPMENT POLICY EQUIPMENT POLICY Page 2 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	1/1/2017 08/14 08/17 1/1/2018	 Policy Committee

Implementation:

Risk Management

Department Managers, ~~the Occupational Health/~~Infection Prevention and Control Nurse ~~(OH/IPC Nurse)~~ and ~~Health and Safety Officer/ Infection Control Representatives (HSIC reps)~~ will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

- They ~~use PPE~~ use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

Facility Name: Parkway Surgery Centers	Policy And Procedure Guideline Name: Safety Management Program (Environment Of Care)	Policy Number: SAFE 104
	Subject Category: SAFETY	Effective Date: 12/01/2016
		Revised Date: 12/14/2017, 1/10/19
		Page 1 Of 4 (Update Field)

Policy: The facilities shall provide guidelines and implement proactive practices, which provide a safe environment of care in relation to property, equipment, patients, personnel and the public.

Purpose: The reduction of physical hazards and the implementation of safe practices enhance environmental safety.

Procedure Guidelines:

Responsibility:

1. Employees are responsible for:
 - A. Intervention when, safety conditions pose a threat to life or health, or threaten damage to equipment or buildings.
 - B. The continuing maintenance of the facility property, eliminating hazards upon discovery.
 - C. Reporting equipment or maintenance problems and incidents of property damage to the Safety Officer or Administrator/ Clinical Director upon discovery.
 - D. Reporting injuries and illness to the Administrator/Clinical Director.
 - E. Obtaining the information necessary to perform tasks in a manner that prevents injury to themselves, patients and others.
2. The Administrator/Clinical Director and designated Safety Officer, as agents of the Quality Assurance Committee are responsible for:
 - A. Environment of Care development, implementation and monitoring.

- B. Report of Safety Surveillance and activities to the Quality Assurance Committee.
- C. Annual review of the Environment of Care policies and guidelines for objectives, scope, performance and effectiveness.

Maintenance and Supervision:

1. Comply with the NFPA 101®, Life Safety Code® (LSC) for maintaining and supervising the facility grounds, buildings and equipment.
2. Maintain equipment and utilities following a preventative maintenance schedule.
3. Maintain sufficient light in the parking and entrance areas to reduce the potential for falls and security concerns.
4. Maintain signs and emergency systems to meet the needs of the visual and hearing impaired.
5. Maintain smoke free environment.
6. Provide facility cleaning, maintenance, and inspection, following a schedule for daily, weekly, monthly, semi-annual and annual activities.
7. Construction and Renovation (Interim Life Safety Plan):
 - A. Meet the existing ambulatory health care occupancy health code requirements for construction or renovation.
 - B. Train staff in alternative safety processes including the use of new specialized equipment and space.
 - C. Train staff to compensate for changes in Life Safety Plan.
 - D. Provide increased facility safety monitoring with construction and renovation included reference to the NFPA 101®, Life Safety Code® (LSC).
 - E. Inspect and monitor components of Life Safety Plan weekly or more frequently if indicated.

Risk Assessment:

1. Provide risk assessment and hazard surveillance to evaluate the impact of the center building, grounds, equipment, occupants, and internal physical systems on patient, employee and public safety.
 - A. Assign a Safety Officer to maintain risk and hazard surveillance.
 - B. Record Hazard surveillance.
 - C. Report environmental hazard and safety surveillance to the Quality Assurance Committee. Provide follow-up to staff concerning safety issue recommendations.
2. Report and document patient, personnel or visitor injury, and occupational illness. Document

incidents on a Variance Report, Occurrence Report, or Incident Report.

- A. Investigate and evaluate each report for opportunities to improve performance.
- B. Include injuries and occupational illness in the report to the Quality Assurance Committee.

Product Safety Recalls:

1. Address a product safety recall upon notification.
 - A. Inventory and remove recalled product from possible use.
 - B. Notify affected medical staff and evaluate a substitute product.
 - C. Inventory patients who may have received a recalled medical device from implant logs or records.
 - D. Consult with the Medical Director and/or Quality Assurance Committee to evaluate the situation and determine an appropriate method for patient notification if an implanted medical device has been recalled. The medical director, as an agent of the Quality Assurance Committee reports the incident to the Medical Executive Committee.

Safety Education:

1. Provide Safety Education and Training at orientation and at least annually thereafter. Address general safety processes; area specific safety and job related hazards.
2. Provide Safety Guidelines in the General Orientation including:
 - A. Review of Safety Policies and Guidelines.
 - B. Body Mechanics.
 - C. Hazardous Materials Communication.
 - D. SDS/ Hazardous Waste.
 - E. Safety Risk / Responsibilities.
 - F. Equipment Safety/Operations Manuals.
 - G. Emergency Preparedness.
 - H. Utility Systems and Electrical Safety.
 - I. Infection Control/Exposure OSHA.
 - J. Reporting of Sentinel Events.

- K.** Variance, accidents/injuries, Security and Safety concerns.
 - L.** Fire and Life Safety.
 - M.** Safety Concerns.
 - N.** Security.
 - O.** OSHA.
- 3.** Include specific safety standards related to safe practices and the safe use, inspection, cleaning and maintenance of specialized equipment in the Department /Job Specific orientation.
 - 4.** Provide updates when new equipment is introduced.
 - 5.** Review General Safety Guidelines annually.

Reference:

Center for Medicare and Medicaid Services (July, 2011). Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery.

The Joint Commission. (2011) Accreditation Standards and Requirements for Ambulatory Surgery Centers

The Accreditation Association for Ambulatory Care. (2011). Accreditation Handbook.

Patient Safety Plan

Premium Surgical Services Center

Las Vegas, Nevada

Originating Department: Environment of Care/Patient Safety Committee

TITLE: Patient Safety Plan	POLICY #: EOC - 1
AFFECTED DEPARTMENTS: All	APPROVED: EOC/Pt. Safety Comm.
EFFECTED DATE: 10/01/10	REVISED DATE: 12/01/2018

PURPOSE:

The purpose of the Patient Safety Plan at Premium Surgical Services Center (PSSC) is to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition and acknowledgment of risks to patient safety and medical/health errors;
- The initiation of actions to reduce these risks;
- The internal reporting of what has been found and the actions taken;
- A focus on processes and systems;
- Minimization of individual blame or retribution for involvement in a medical/health care error
- Organizational learning about medical/health care errors;
- Support of the sharing of that knowledge to effect behavioral changes

The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety. This is accomplished through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at PSSC. The Patient Safety Plan developed by the interdisciplinary EOC/Patient Safety Committee (Dr. Stile, Shannon Moreno, RN, Dr. Barson, Luis Martinez, ST, Ronnie Rodriguez) outlines the components of the Patient Safety Program.

PATIENT SAFETY PROGRAM:

I. SCOPE OF ACTIVITIES:

A. The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence and maintains and improves patient safety. Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Environment of Care/Patient Safety Committee (includes Dr. Stile, Shannon Moreno, RN, Dr. Barson, Luis Martinez, ST, Ronnie Rodriguez) to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:

1. No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient
2. Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient
3. Any Medication Error
4. Any Adverse Drug Reaction
5. Any Transfusion Reaction
6. Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome chance of a serious adverse outcome.
7. Sentinel Event

B. The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including Medical Staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:

1. Patient Rights
2. Assessment of Patients
3. Care of Patients
4. Patient/Family Education
5. Continuum of Care
6. Leadership
7. Improving Organization Performance
8. Management of Information
9. Management of Human Resources
10. Management of the Environment of Care
11. Surveillance, Prevention, and Control of Infection

II. METHODOLOGY:

A. The Interdisciplinary EOC/Patient Safety Committee (Dr. Stile, Shannon Moreno, RN, Dr. Barson, Luis Martinez, ST, Ronnie Rodriguez) is responsible for the oversight of the Patient Safety Program. The EOC/Patient Safety Committee Chairperson (Dr. Stile) will have administrative responsibility for the program, or the EOC/Patient Safety Committee (Dr. Stile, Shannon Moreno, RN, Dr. Barson, Luis Martinez, ST, Ronnie Rodriguez) may assign this responsibility to another member of the committee (Shannon Moreno, RN).

B. All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Administrator (Dr. Stile), who will aggregate occurrence information and present a report to the EOC/Patient Safety Committee (Dr. Stile, Shannon Moreno, RN, Dr. Barson, Luis Martinez, ST, Ronnie Rodriguez) on a quarterly basis. The EOC/Patient Safety Committee will analyze the report information and determine further patient safety activities as appropriate.

C. Through review of internal data reports and reports from external sources (including, but not limited to JCAHO sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the Performance Improvement priority criteria grid, the EOC/Patient Safety Committee (Dr. Stile, Shannon Moreno, RN, Dr. Barson, Luis Martinez, ST, Ronnie Rodriguez) will select at least one high-risk safety process for proactive risk assessment annually. The proactive risk assessment will include:

1. Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be.
2. For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
3. Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
4. Test and implement the redesigned process
5. Identify and implement measures of the effectiveness of the redesigned process
6. Implement a strategy for maintaining the effectiveness of the redesigned process over time
7. Ensure that all components of the health care organization are integrated into and participate in the organization-wide program.

D. Upon identification of a medical/health care error, the patient care provider will immediately:

1. Perform necessary healthcare interventions to protect and support the patient's clinical condition
2. As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked
3. Contact the patient's physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
4. Preserve any information related to the error (including physical information). Examples of preservation of physical information are: preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record
5. Report the medical/health care error to the staff member's manager and Administrator.
6. Submit the occurrence report to the Administrator (Dr. Stile) per organizational policy.

E. Any individual in any department identifying a potential patient safety issue will immediately notify his or her manager and document the findings on an occurrence report. The occurrence report will be submitted to the Administrator

F. Staff response to medical/health care errors is dependent upon the type of error identified:

1. No harm errors - (including "no harm" medication errors) - staff will document in the medical record the circumstances regarding the no harm error on an occurrence report form, submit the form to the Administrator and notify their immediate supervisor
2. Mild-Moderate Adverse Outcome Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts in the medical record and on an occurrence report - submitting the report to the Administrator.
3. Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will document facts on an occurrence report - submitting the report to the Administrator.
4. Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate;

- notify his/her manager (Shannon Moreno, RN or Ronnie Rodriguez) and Administrator (Dr. Frank Stile), document facts in the medical record and on an occurrence report - submitting the report to the Administrator.
5. Transfusion Reaction – We do not handle blood products at our facility.
 6. Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor, take appropriate action and document the findings on an occurrence report. The occurrence report will be submitted to the Administrator (Dr. Frank Stile).
 7. Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, and his/her manager (Shannon Moreno, RN or Ronnie Rodriguez) and Administrator (Dr. Frank Stile) carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure document facts appropriately in the medical record and on an occurrence report - submitting the report to the Quality Management Division.
 8. Near Miss - staff will report the near miss event to his/her manager (Shannon Moreno, RN or Ronnie Rodriguez), describe the facts of the near miss on an occurrence report and submit the report to the Administrator (Dr. Frank Stile) .
 9. At the direction of the Administrator (Dr. Frank Stile) of the Medical Staff all sentinel events and near miss occurrences will have a root cause analysis conducted.

G. It is the intent of this organization to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment.

H. The organization will focus on improving systems and processes and on remedial actions to assist rather than punish staff members. The Environment of Care/Patient Safety will review the course of action to prevent error recurrence.

I. Sentinel Events - staff members involved in a sentinel event occurrence will receive support from the Administrator (Dr. Frank Stile) of the Medical Staff regarding the staff member's professional and emotional reconciliation of the sentinel event. The Environment of Care/Patient Safety and Care Oversight Committees (Dr. Stile, Shannon Moreno, RN, Dr. Barson, Luis Martinez, ST, Ronnie Rodriguez) encourage the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the department supervisor

J. On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.

K. The Patient Safety Program includes an annual survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.

L. Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Environment of Care/Patient Safety Committee (Dr. Stile, Shannon Moreno, RN, Dr. Barson, Luis Martinez, ST, Ronnie Rodriguez) will receive a report verifying compliance with informing the patient about outcomes of care.

M. Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care.

N. Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. Staff will be educated and trained on the provision of an interdisciplinary approach to patient care

O. Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

P. Quarterly reports from the Environment of Care/Patient Safety Committee (Dr. Stile, Shannon Moreno, RN, Dr. Barson, Luis Martinez, ST, Ronnie Rodriguez) will be submitted to the Quality Council, Care Oversight Committee of the Medical Staff and Board QI Committee (Dr. Stile, Shannon Moreno, RN, Dr. Barson, Luis Martinez, ST, Ronnie Rodriguez), which exists as the oversight committee for the Environment of Care/Patient Safety Committee (Dr. Stile, Shannon Moreno, RN, Dr. Barson, Luis Martinez, ST, Ronnie Rodriguez).

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

Revised: 03/2012

Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017, 3/2018

I. Introduction:

The Patient Safety Program supports and promotes the mission, vision and values of Innovative Procedural and Surgical Center through organization prioritization of patient, visitor, and employee safety.

The Patient Safety Program is implemented through the Patient Safety Committee and is supported by leadership's promotion of a safety culture that:

- Encourages recognition, reporting, and acknowledgment of risks to patient/visitor and employee safety and medical/healthcare errors
- Initiates/monitors actions to reduce risks/errors
- Internally reports findings and actions taken
- Promotes a blame-free culture facilitating the reporting and follow-up on safety concerns, errors and adverse events
- Educates staff and physicians to assure participation in the program

II. Purpose:

The Patient Safety Program is designed to enhance patient care delivery and prevent adverse outcomes of care by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach focuses on actual and potential occurrences; ongoing proactive risk management; and integration of patient-safety priorities in the development and revision of processes, functions and services.

III. Mission, Vision and Values:

In support of the mission, vision and values of this organization the Patient Safety Program promotes:

- Collaboration among staff members, physicians and other providers to deliver comprehensive, integrated and quality health care
- A focus on comprehensive, integrated quality service
- Open and honest communication to foster trust relationships among staff members, physicians, other providers and patients

IV. Objectives:

The objectives of the Patient Safety Program are to:

- Encourage organizational learning about adverse or potentially adverse events
- Incorporate recognition of patient safety as an integral job responsibility
- Provide patient safety education

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

Revised: 03/2012

Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017, 3/2018

- Involve patients in decisions about their health care and promote open communication
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate proactive measures
- Report internally the finding and actions taken to reduce risk
- Support sharing of knowledge to effect change

V. Responsibilities/Duties:

The Patient Safety Committee provides a multidisciplinary collaboration for the collection and analysis of risk to patient safety and the dissemination of information on identified risk for the purpose of improving patient care. It shall review reports on occurrences including near misses to sentinel events. It shall identify those individuals or groups best situated to perform a root cause analysis and develop and implement an action plan for identified issues. It shall review, analyze and disseminate the information it receives, as appropriate, to the QI Committee and the Governing Board of Managers. It shall provide recommendations concerning identified risks, approve plans for corrective action and evaluate the implementation of corrective actions taken.

The Patient Safety Committee of Innovative Procedural and Surgical Center is comprised of the Patient Safety Officer, two providers of health care who treat patients at the facility, including one member of the medical staff and one member of the nursing staff, and the Chief Executive Officer of the facility.

The Patient Safety Committee shall meet at least once every calendar quarter.

The Governing Board of Managers shall designate an officer or employee of Innovative Procedural and Surgical Center to serve as the Patient Safety Officer of the facility.

The Patient Safety Officer of the facility will:

- Serve on the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties pursuant to NRS 439.835.

Duties pursuant to NRS 439.835 are

- a) A person who is employed by IPSC shall, within twenty-four (24) hours after becoming aware of a sentinel event that occurred at IPSC, notify the Patient Safety Officer of the event
- b) The Patient Safety Officer will, within thirteen (13) days after receiving notification, report the date, the time and a brief description of the sentinel event to the Nevada State Health Division and facility representative if that person is different from the Patient Safety Officer.

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

Revised: 03/2012

Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017, 3/2018

- c) If the Patient Safety Officer of IPSC personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at IPSC, the Patient Safety Officer will, within fourteen (14) days after discovering or becoming aware of the sentinel event report the date, time and brief description of the event to those listed in b) above.
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at IPSC
 - Report to the IPSC Patient Safety Committee regarding any action taken in accordance to the above paragraph
 - Upon discovery notify the CEO immediately

The Patient Safety Committee shall:

- Receive reports from the Patient Safety Officer
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred at the medical facility
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment at the facility
- Make recommendations to the Governing Board of Managers to reduce the number and severity of sentinel events and infections that occur at the facility
- At least once each calendar quarter, report to the Governing Board of Managers of the facility regarding:
 - a) The number of sentinel events that occurred at the facility during the preceding calendar quarter
 - b) The number and severity of infections that occurred at the facility during the preceding calendar quarter
 - c) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the facility
- Adopt patient safety checklists and patient safety policies
 - a) The patient safety checklists adopted pursuant to this section must follow protocols to improve the health outcomes of patients at the facility and must include without limitation:
 - *Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care
 - *Checklists for ensuring that employees of the facility and contractors with the facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary
 - *A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received proper

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

Revised: 03/2012

Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017, 3/2018

instructions concerning prescription medications, instructions concerning aftercare, and any other instructions concerning his or her care upon discharge

*Any other checklists which may be appropriate to ensure the safety of patients at the facility

*A policy for appropriately identifying a patient before providing treatment.

Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of health care. The personal identifiers may include, without limitation, the name and date of birth of the patient

*A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of health care at the facility including, without limitation, protocols relating to hand hygiene

*A policy to ensure compliance with the patient safety checklists and patient safety policies adopted, which may include, without limitation, active surveillance. Active surveillance may include, without limitation, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials

- Focus on fall prevention activities: Staff is trained on fall-related topics including extrinsic and intrinsic risk factors, occurrence of syncope during IV starts, anti-fall precautions, importance of proper equipment use and maintenance, fall reporting procedures.
 - A fall is any unintentional change in position where the patient ends up on the floor or other lower level. This includes witnessed and un-witnessed falls and includes whether there is an injury or not. Serious injuries can occur including fractures, lacerations and can lead to emergency room visits or hospital admissions.
 - There are many factors that can increase the risk of patient falls which include, but are not limited to: use of medications affecting the central nervous and/or cardiovascular system, i.e. benzodiazepines, sedatives, hypnotics, antihypertensives; chronic degenerative illnesses i.e. arthritis, cataracts, dementia and diabetes; visual impairment; unsteady gait.
 - Ensure a safe environment for patients:
 - Floors will be flat, dry, nonslip and free of area/throw rugs or other loose coverings
 - All spaces will be clear of obstacles and evenly illuminated
 - Assistive devices are present in bathrooms to accommodate disabled patients
 - Functioning emergency call systems are present in all patient care areas, bathrooms and changing rooms
 - Procedure tables are equipped with proper safeguards, such as side rails, grip handles and step risers

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

Revised: 03/2012

Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017, 3/2018

- Wheelchairs have appropriate seat cushioning and anti-rollback devices, and are locked when in a stationary position
- Nonskid footstools are available to assist patients climb on and off procedure tables
- Side rails and wheel locks are engaged whenever patients are on procedure tables or gurneys
- Patients are instructed to dangle their legs over the side of the table before moving to an upright position
- Whenever patients are left unattended, procedure tables and gurneys are left in the lowest position
- Patients receiving sedative agents are always under close supervision
- Monitor and document the effectiveness of the patient identification policy adopted
- At least annually, review the patient safety checklists and patient safety policies adopted, and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at this facility
- Revise a patient safety checklist and patient safety policy as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols
- On or before July 1st of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.
- The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.

VI. Scope:

The types of occurrences to be addressed include, but are not limited to, sentinel events, near misses, and actual events related to:

- Patient Safety
- Adverse drug events (medication errors and adverse drug reactions)
- Health acquired infections
- Patient Falls
- Other patient incidents/unexpected clinical/medical events
- Unsafe conditions
- Visitor safety/Visitor incidents
- Employee Safety

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

Revised: 03/2012

Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017, 3/2018

- Blood/body fluid exposures
- Occupational diseases
- Communicable disease exposures
- Musculoskeletal injuries
- Immunization programs
- Other employee incidents
- Environmental safety
- Product recalls
- Drug recalls
- Product/equipment malfunction
- Construction-Infection Control Risk Assessment
- Water Quality
- Air Quality
- Disaster Planning
- Security Incidents
- Workplace Violence

Data from external sources, including but not limited to:

- Centers for Disease Control (CDC)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Occupational Safety and Health Administration (OSHA)
- Nevada State Health Division
- Published literature

VII. Definitions:

Sentinel Event is defined as an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function.

Occurrence is an event that is not consistent with routine patient care of procedure in which either did not or could have resulted in injury, loss to a patient or visitor or which may give rise to a claim against the facility, an employee of the facility, or a member of the facility medical staff.

Near Misses are any process variation which did not affect the outcome due to a screening by chance but for a recurrence carries a significant chance of a serious adverse outcome. Some may call it a potential for error.

Error is an unintended act, either omission or commission, or an act that does not achieve its outcome such as medication errors and adverse drug events or reactions.

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

Revised: 03/2012

Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017, 3/2018

Hazardous Condition is any set of circumstances, exclusive of the disease or condition the patient is being treated for, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

Facility Acquired Infections are a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was treated at the facility, including surgical site infections.

VIII. Structure:

The authority for the Patient Safety Plan rests with the CEO, Governing Board of Managers, Quality Improvement/Quality Assurance Committees, and Patient Safety Officer, and has delegated the authority to implement and maintain activities described in this plan to the IPSC Patient Safety Committee.

IX. Quality Review Information

To the extent possible, and in a manner consistent with the protection of confidentiality of quality assurance and patient safety data, pertinent information will be shared between the Quality Improvement Program and the Patient Safety Program.

In an attempt to protect quality review information from discovery, all quality review documents must be labeled as a Quality Review document. Documents should be in a formal format, handled by a limited number of individuals and secured in the Director of Nursing's office accessible only to designated individuals. Nevada Revised Statutes protecting Quality documents in NRS 49.265.

X. Education:

Quarterly/Annual Staff and Physician/Provider education as applicable includes, but is not limited to the following topics:

- Fire Drills (Quarterly)
- Emergency and Disaster Drills
- Workplace violence
- Customer service
- Creating, implementing, achieving and maintaining a culture of safety
- Risk management and error prevention
- Teamwork

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

Revised: 03/2012

Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017, 3/2018

XI. Safety Improvement Activities:

Specify Measures for an annual focus (Examples listed below)

- Patient Satisfaction Surveys
- Medical Records review; legible documentation, clear, complete, signed
- Complaint and resolution-to improve care and satisfaction (trends)
- Confidentiality; ensure patient and employee information is secure
- Appointments/scheduling process; accessibility to physician
- Informed consent policy and procedure
- Medication management and reconciliation
- Telephone response time to callers
- Occurrence review

Give consideration to measures that facilitate safe practices (Examples listed below)

- Involve patients in their health care; consider literacy issues and cultural values, partner with patients in developing and planning their care
- Use a team approach to safety; hold focused safety meetings
- Endorse open, effective communication; identify shared values and attitudes among all members. Interview and/or survey staff for attitudes, perceptions and communication barriers
- Encourage error reporting to include near miss events. Institute a non-punitive reporting that is confidential and timely.
- Ensure employee and patient information or event reports shared with staff for educational purposes do not identify individuals
- Facilitate communication skills learning (teamwork)
- Examine physical premises to identify and correct potential hazardous conditions
- Orient physicians and new employees to risk management and patient safety concepts
- Conduct patient safety rounds
- Provide education and training on high risk processes

XII. Methodology:

Structure:

- Proactive risk prevention strategies
- Identification of high risk areas
- General incidences (Patient injuries)
- Potential or actual adverse events (medication errors)

Method: Establish a process for

- Identification, selection, prioritization
- Data collection and analyses

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

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Effective Date 01/2012

Revised: 03/2012

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- Development of actions
- Implementation
- Reporting
- Follow-up

Process Improvement: Establish teams/individual staff members to implement processes and to monitor for effectiveness. Utilize applicable tools to facilitate improvement for example

- PDCA: Plan, Do, Check, Act with focus on process improvement
- FMEA: Failure Mode Effect Analysis a systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk
- RCA: Root Cause Analysis is a retrospective approach to error analysis that identifies what and how the event occurred and why it happened. The focus in on the process and systems not individuals

XIII. Program Evaluation:

The Patient Safety Committee will submit an Annual Report to the Quality Improvement Committee and include:

- Definition of the scope of occurrences including sentinel events, near misses and serious occurrences
- Detail of activities that demonstrate the Patient Safety Program has a proactive component by identifying the high-risk process selected
- Results of the high-risk or error-prone processes selected for ongoing measurement and analysis
- A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles
- The results of how input is solicited and participation from patients and families in improving patient safety is obtained
- The results of the program that assesses and improves staff willingness to report errors
- A description of the examples of ongoing education and training programs that are maintaining and improving staff competence

INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

Subject: Patient Safety Plan

Effective Date 01/2012

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Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016, 1/2017, 3/2018

Adapted from Medical Mutual Template Safety Plan and Nevada State Health Division Regulations

2019

Ambulatory Health Care National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

NPSG.01.03.01

Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Use medicines safely

NPSG.03.04.01

Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01

Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01

Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Prevent infection

NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

NPSG.07.05.01

Use proven guidelines to prevent infection after surgery.

Prevent mistakes in surgery

UP.01.01.01

Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01

Mark the correct place on the patient's body where the surgery is to be done.

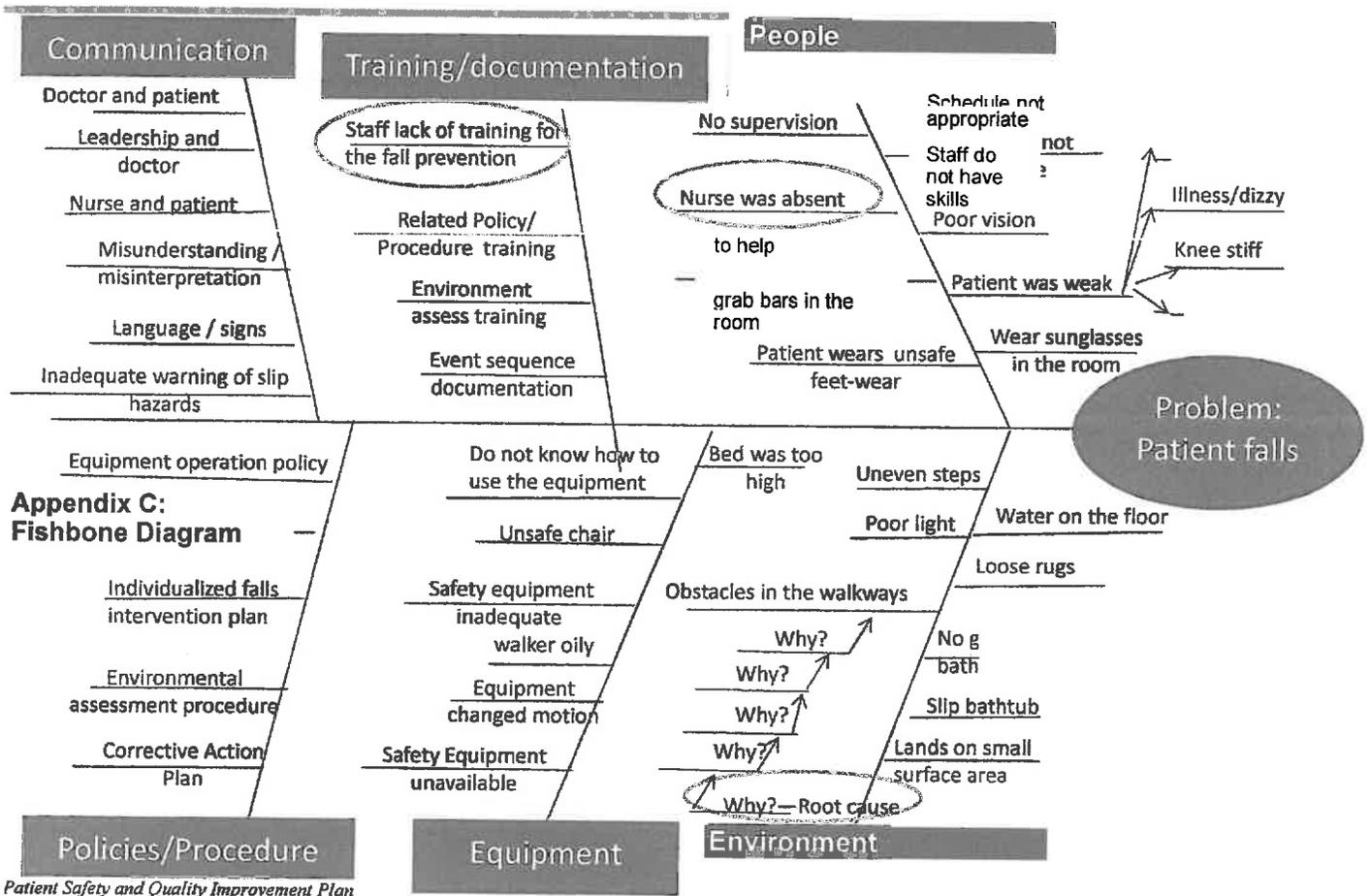
UP.01.03.01

Pause before the surgery to make sure that a mistake is not being made.

Retrieved 02.11.19 https://www.jointcommission.org/assets/1/6/2019_NPSGs_final.pdf
2019 Ambulatory Health Care National Patient Safety Goals

Facility Name: Valley View
Surgery Center

Appendix C: Fishbone Diagram



Patient Safety and Quality Improvement Plan

Retrieved 02.12.19 <http://premierinc.com/safety/topics/guidelines/downloads/NHSN Manual PatientSafety Protocol CU.RENT b.pdf>
Fishbone Diagram

Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:

Person Completing Worksheet:

Date:

Telephone/ Email:

Cycle:

Patient Safety Committee Members

CEOs/CFOs

Patient Safety Officer

Infection Control Officer

Other Medical Staff

Other team members

Aim: (Describe the overall SMART goal that your team wishes to achieve.)

Plan:

1. List the tasks needed to set up this test of change.

2. Predict what will happen when the test is carried out.

3. List the steps to develop the test-who, what, and when.

Steps

By Whom

By When

Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.

Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.

Describe what modifications to the plan will be made for the next cycle based on what you learned.

- Adapt: modify changes and repeat PDSA Cycle
- Adopt: expanding changes throughout organization
- Abandon: change approach and repeat PDSA cycle

	Pre-Op	OR /Procedure	PACU
15. *De-briefing after completion of procedure			
a. Name of procedure performed			
16. *De-briefing after completion of procedure			
b. Name of procedure performed			
c. Sponge, sharp count performed <input type="checkbox"/> N/A			
d. Specimens identified and labeled <input type="checkbox"/> N/A			
e. *Any equipment problems to be addressed <input type="checkbox"/> N/A			
f. *Key concerns for recovery and management of this patient <input type="checkbox"/> N/A			
17. Sterilization Documentation completed/initialed if applicable			
18. O. R. Record Complete to include out of OR time			
# 12 to #18 completed by			
Any G-Codes occurrences? <input type="checkbox"/> No <input type="checkbox"/> Yes List G-Code _____ See below			
19. Admit time to PACU			
20. Post Op Orders Noted			
21. Signature of Discharging MD; Discharge time on PACU record			
22. Discharge time to home or transfer to hospital noted <input type="checkbox"/> Yes			
23. Copy of VVSC's prescriptions <input type="checkbox"/> N/A <input type="checkbox"/> Yes If discharged with opioid prescription, pt. signed consent to opioid therapy treatment signed. <input type="checkbox"/> Yes			
24. Name of responsible adult pt. discharged to noted on discharge instructions			
25. Phone number of the physician doing surgery or procedure on discharge instructions			
Any G-Codes occurrences? <input type="checkbox"/> No <input type="checkbox"/> Yes List G-Code _____ See below			
Nurse Name: Printed	Signature:	/ Initials:	
Nurse Name: Printed	Signature:	/ Initials:	
Nurse Name: Printed	Signature:	/ Initials:	
Nurse Name: Printed	Signature:	/ Initials:	
Nurse Name: Printed	Signature:	/ Initials:	
RN Co-sign for LPN: Printed	Signature:	/ Initials:	

****ALL AREAS MUST BE SIGNED OFF AT THE TIME OF DISCHARGE FROM PACU FOR CHART TO BE COMPLETE**** First and last name initials signify the nurse has completed the listed responsibility. *Revisions/Additions to this form adopted from AORN Comprehensive Surgical Checklist 2016 that incorporated WHO, Joint Commission-Universal Protocol 2010 National Patient Safety Goals.

Measure Description	G-Code
Patient Burn	G8908 Patient documented to have received a burn prior to discharge
Patient Fall	G8910 Patient documented to have experienced a fall within VVSC
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	G8912 Patient documented to have received/experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant
Hospital Transfer/Admission	G8914 Patient documented to have experienced hospital transfer/admission

Appendix F: Safety Policy Example
VALLEY VIEW SURGERY CENTER

Section Appendix Nursing Services

Policy: Nursing Services

Subject: Patient Identification

Effective Date: 08/11

Revision/Review Date: 07/18

Page 22

POLICY:

To improve the accuracy of patient identification, all VVSC's staff members in their respective areas will use the "two patient identifiers." The first identifier will be the first and last name of the patient. The second identifier will be the patient's date of birth. The practice of having the patient involved in identifying themselves and using "two patient identifiers" is essential in improving the reliability of the patient's identification process. The use of two identifiers also helps ensure that a correct match is made between the service or treatment and the individual. This process will help eliminate errors and enhance patient care.¹

PROCEDURE:

A. At registration:

1. If not previously obtained prior to the day of the surgery or procedure, the registration staff will secure photo identification (driver's license or State issued) and if the patient has insurance, an insurance card. The staff member will call the patient by his/her first name. Once the patient acknowledges his/her first name, the staff member will ask the patient to state their last name. This is the first patient identifier.
2. The staff member will ask the patient to state his/her full date of birth to include month, day, and year. This is the second patient identifier.
3. If the above two identifiers are accurate as documented on the patient's photo identification and on the insurance card, the patient is identified as the unique individual and correct identity is confirmed.
4. If the above first or second identifiers are not accurate and identical, the identity of the patient is not correct. Follow up measures will be taken to correctly identify the patient before admission to VVSC. Follow up measure include and not limited to further questions regarding documents of identity, legal first and last names, nicknames, middle names, etc.
5. The patient will be admitted to VVSC only if the above two identifiers are correct.

B. PreOp Area:

1. The PreOp admitting licensed nurse will use the same two patient identifiers. The licensed nurse will call the patient by his/her first name and ask the patient to say his/her last name. The licensed nurse will ask the patient to state his/her full date of birth to include month, day, and year. The licensed nurse will compare the answers provided by the patient to the patient's name label and verify correct identification of the patient.
2. The PreOp licensed nurse will admit the patient to the PreOp area only if the two identifiers and the patient's name label are correct.
3. The PreOp licensed nurse will place the patient's identification band on the patient's wrist.

¹ Retrieved 02.11.19, professionals.site.apic.org/patient-identification, *Identify your patient, Infection Prevention and You.*

Appendix F: Safety Policy Example
VALLEY VIEW SURGERY CENTER

Section Appendix Nursing Services

Policy: Nursing Services

Subject: Patient Identification

Effective Date: 08/11

Revision/Review Date: 07/18

Page 23

C. Procedure Room:

1. Before taking the patient into the procedure room, the circulating nurse will use the same two patient identifiers and compare the patient's answers against the patient's identification band and the name label on the patient's chart for correction patient identification.
2. The patient's identify is announced to the surgical team members as noted in "Time-Out" Policy.

D. PACU area:

1. The PACU nurse will identify the patient by checking the patient's identification name band and name label when receiving report from the anesthesia provider or the transporting RN from the procedure room. The PACU nurse will identify the patient using the same two patient identifiers once the patient can participate in the identification process.

- E. When administering medications or providing any other treatments as ordered by the physician, the licensed nurse will use the designated two identifiers.**

History of review/revision: 12/11, 08/13, 12/14, 10/15, 11/16, 12/17

References:

1. Retrieved 02.11.19
https://www.jointcommission.org/assets/1/6/2019_NPSGs_final.pdf. 2019
Ambulatory Health Care National Patient Safety Goals
2. Retrieved 02.11.19
https://www.jointcommission.org/assets/1/6/NPSG_Chapter_AHC_Jan2019.pdf
National Patient Safety Goals Joint Commission
3. Retrieved 02.11.19, professionals.site.apic.org/patient-identification, *Identify your patient, Infection Prevention and You.*

Who Should Know This Policy

All Employees

Chief Nurse Officer

Medical Director

The following positions are responsible for the accuracy of the information contained in this document:

Administrator Governing Board Chief Nurse Officer

Reference: Section Appendix Nursing Services: *Patient Identification*

Please revise and expand this template to meet your facility's needs.

**Facility Name: Kindred Hospital Las Vegas DeLima
Campus**

QUALITY AND PATIENT SAFETY PLAN Template

DATE:

~~01/01/201702/1926/189MM/~~



This plan was created and revised by the Kindred Hospital Las Vegas DeLima Campus ~~(facility name)~~ Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

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Patient Safety Committee/Program
Kindred Hospital Las Vegas DeLima Campus ~~Facility name:~~
102 East Lake Mead Parkway
Henderson, Nevada 89105

Facility Name Kindred Hospital Las Vegas DeLima Campus

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702-790-0827

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Chief Clinical Officer
702-856-4115
Facility Address

Facility contact information

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Contents

Commitment to Patient Safety.....	<u>322</u>
Mission, Vision, and Values	<u>323</u>
Scope and Purpose.....	<u>423</u>
Roles and Responsibilities.....	<u>444</u>
Roles and Responsibilities	5
Objectives and Goals of the Quality and Patient Safety Plan	<u>888</u>
Components and Methods	<u>1288</u>
Root Cause Analysis.....	<u>1399</u>
Model for Improvement	<u>131010</u>
Data Collection and Reporting.....	<u>151111</u>
Assessment of the Quality and Patient Safety Plan	<u>161212</u>
Patient Safety Checklists and Patient Safety Policies	<u>161313</u>

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Approval of Patient Safety Plan 181515

Reference..... 191515

Appendix A: Terms and Definitions 201616

Appendix B: Patient Safety Goals 231818

Appendix C: Fishbone Diagram..... 241919

Appendix D-1: PDSA Worksheet..... 252020

Appendix D-2: PDSA Monthly / Quarterly Progress Report 272222

Appendix E: Checklist Example: Injuries from Falls and Immobility..... 282323

Appendix F: Policy Example 292424

Commitment to Patient Safety

Kindred Hospital Las Vegas DeLima Campus (Facility name) is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

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Mission, Vision, and Values

In support of our mission, vision, and values, (facility name Kindred Hospital Las Vegas DeLima Campus 's) Patient Safety and Quality Improvement program promotes:

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- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, members, and patients and their families, to ensure accountability for the patient safety priorities.

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- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in (facility name Kindred Hospital Las Vegas DeLima Campus) are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

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This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, (facility name Kindred Hospital Las Vegas DeLima Campus) has developed this Patient Safety Plan.

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

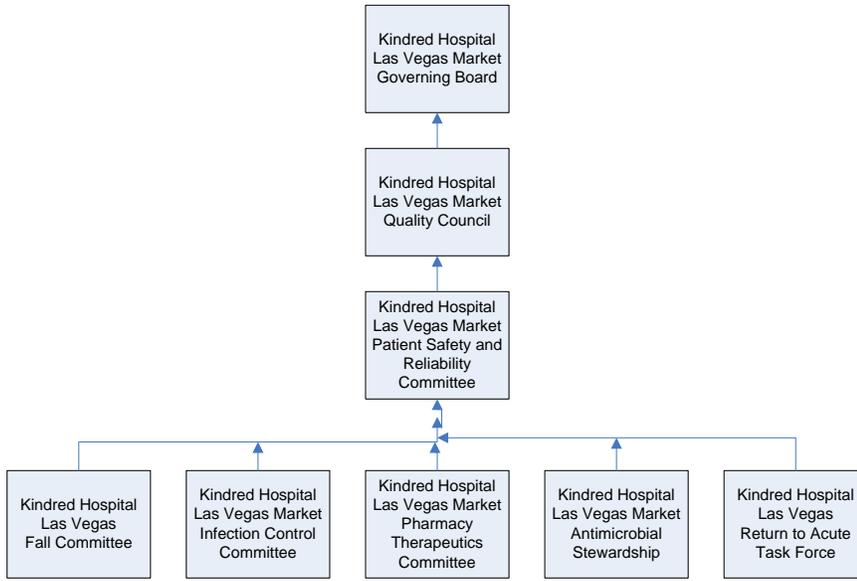
- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.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

Roles and Responsibilities

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

executed successfully.

The Patient Safety Committee Organization



R

Roles and Responsibilities

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

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

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

The roles and responsibilities are defined below (Please modify them as needed.)

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

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

Root Cause Analysis (RCA) Team Responsibilities ~~(please revise as needed)~~

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.

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- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

~~(Additional responsibilities here if needed)~~

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

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

~~(Additional responsibilities here if needed)~~

RCA Team Leader Responsibilities ~~(please revise as needed)~~

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Provide vision and leadership to the Root Cause Analysis process
- Work with the Director of Quality Management to assure process changes are implemented
- Guide the staff in the process of discovery and mitigation of future process failures

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~~(Please provide the responsibilities here)~~

Executive or Governing Body Staff Responsibilities ~~(please revise as needed)~~

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

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(Please provide additional responsibilities here if needed)

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

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

<u>Objective</u>	<u>Goals</u>	<u>Plan</u>	<u>Planned Completion Date</u>	<u>Responsible Party</u>
<u>CLABSI Reduction Prevention</u>	<u>Maintain a CLABSI rate of less than 0.70 by 15%</u>	<ol style="list-style-type: none"> 1) <u>Use Tegaderm Dressings</u> 2) <u>CHG Bathing Program</u> 3) <u>Staff education and competencies on hire and annually thereafter.</u> 	<u>1st Quarter 2017-12/31/18</u>	<u>ICP/CCO</u>

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		<p>4) <u>Develop nurse-driven protocol for discontinuation of lines</u></p> <p>— <u>RCA performed for each event</u></p> <p><u>Use Tegaderm Dressings</u></p> <p>— <u>Update the education for new dressing kit</u></p> <p>— <u>Conduct competencies</u></p> <p>5) <u>CHG Bathing Program</u></p>		
<u>CAUTI Prevention</u>	<p><u>Maintain a Reduce CAUTI rate of less than by <u>10%0.52</u></u></p>	<p>1) <u>Staff education and competencies on hire and annually thereafter</u></p> <p>2) <u>Evaluate use of external female urine systems</u></p> <p>— <u>RCA performed for each event</u></p> <p><u>Skills laboratory for peri-care, foley care and cath secure</u></p> <p>3) <u>Competency-based demonstration</u></p>	<p><u>1st Quarter 2017/12/31/18</u></p>	<p><u>ICP/CCO</u></p>
<u>HAPNOWPU Prevention</u>	<p><u>Reduce HANOWPU by 10%</u></p>	<p>1) <u>Use of Patient Safety Index to assure HAPU prevention</u></p> <p>2) <u>Braden Scale, Repositioning, Assessment and Wound Education to</u></p>	<p><u>Quarterly Assessment 12/31/18</u></p>	<p><u>Wound Care Coordinator/ Chief Clinical Officer</u></p>

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		<u>Patient Family Score</u> <u>3) RCA done for each event</u> <u>Use of Patient Safety Index to assure HAPU prevention</u> <u>Braden Scale</u> <u>Repositioning Assessment and Wound Education to Patient Family Score</u>		
<u>Antimicrobial Stewardship</u> <u>Employee Health</u>	<u>Reduce Antibiotic usage to < 35% of total drug cost</u> <u>Improve flu vaccine by 5%</u>	<u>1) Enhance the Patient Safety Dashboard for Antimicrobial Therapy Use</u> <u>2) Incorporate the Pharmacist/IC P/ Infectious Disease MD rounding Staff, physician and Leadership Education</u> <u>Vaccine Education</u> <u>3) Use of isolation masks by non-vaccinated personnel in clinical areas</u>	<u>12/31/183rd Quarter 2017</u>	<u>Director Pharmacy/IC P/CCO/ID Medical</u> <u>Director Employee Health</u> <u>Nurse/ Chief Clinical Officer</u>
<u>Antimicrobial Stewardship</u>	<u>Reduce use of unnecessary antibiotic therapies</u>	<u>Enhance the Patient Safety Dashboard for Antimicrobial Therapy Use</u> <u>Incorporate the Pharmacist/IC</u>	<u>2nd Quarter 2017</u>	<u>Director Pharmacy</u>

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		<u>P/Infectious Disease MD rounding</u> <u>Staff and Leadership Education done 4th Quarter 20016</u>		
<u>Fall Reduction</u>	<u>Reduce falls by 10%</u>	<ol style="list-style-type: none"> 1) <u>Fall risk assessment completed for each patient, each shift</u> 2) <u>Re-implement market Fall Reduction Performance Improvement Team</u> 3) <u>Staff education on hire and annually thereafter</u> 4) <u>Post-fall assessment completed for each event</u> 	<u>12/31/18</u>	<u>DQM/CCO</u>
Objective	Goals	Plan	Planned Completion Date	Responsible Party

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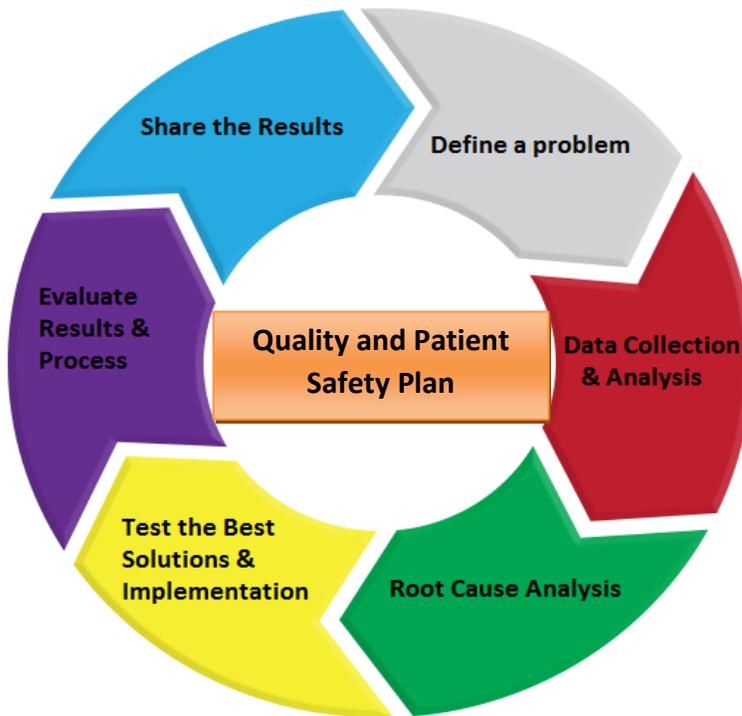
Components and Methods

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

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

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Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in (facility name Kindred Hospital Las Vegas DeLima Campus) to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

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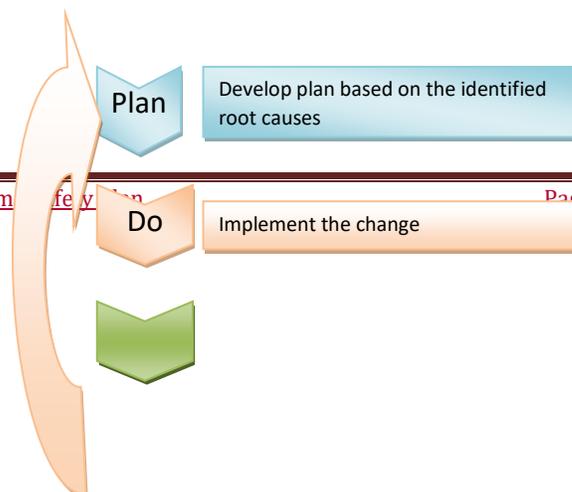
Fishbone Diagram

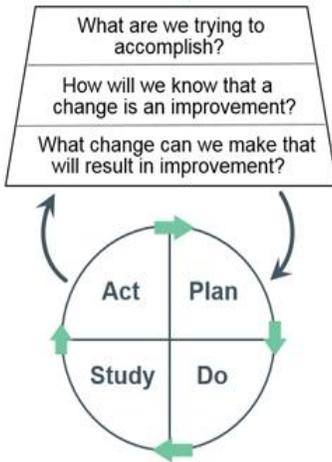
Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why's technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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





The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

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PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

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Data should drive any quality and patient safety effort. Kindred Hospital Las Vegas Sahara Campus is using the Kindred Event Reporting System for tracking the incident and sentinel events, NHSN for reporting healthcare infection data, WebIZ for reporting vaccinations, and Business Warehouse and Meditech for internal data collection.

Data Collection and Reporting

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Data should drive any quality and patient safety effort. (Facility name Kindred Hospital Las Vegas DeLima Campus) is using Protouch (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) Infection Prevention IPAC Administrator, and the Kindred Hospital Di for internal data collection.

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

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



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;

- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

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

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

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

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference—a checklist example is shown in **Appendix E**.)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpo.e.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at

Facility Name Kindred Hospital Las Vegas DeLima Campus:-

http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURR ENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

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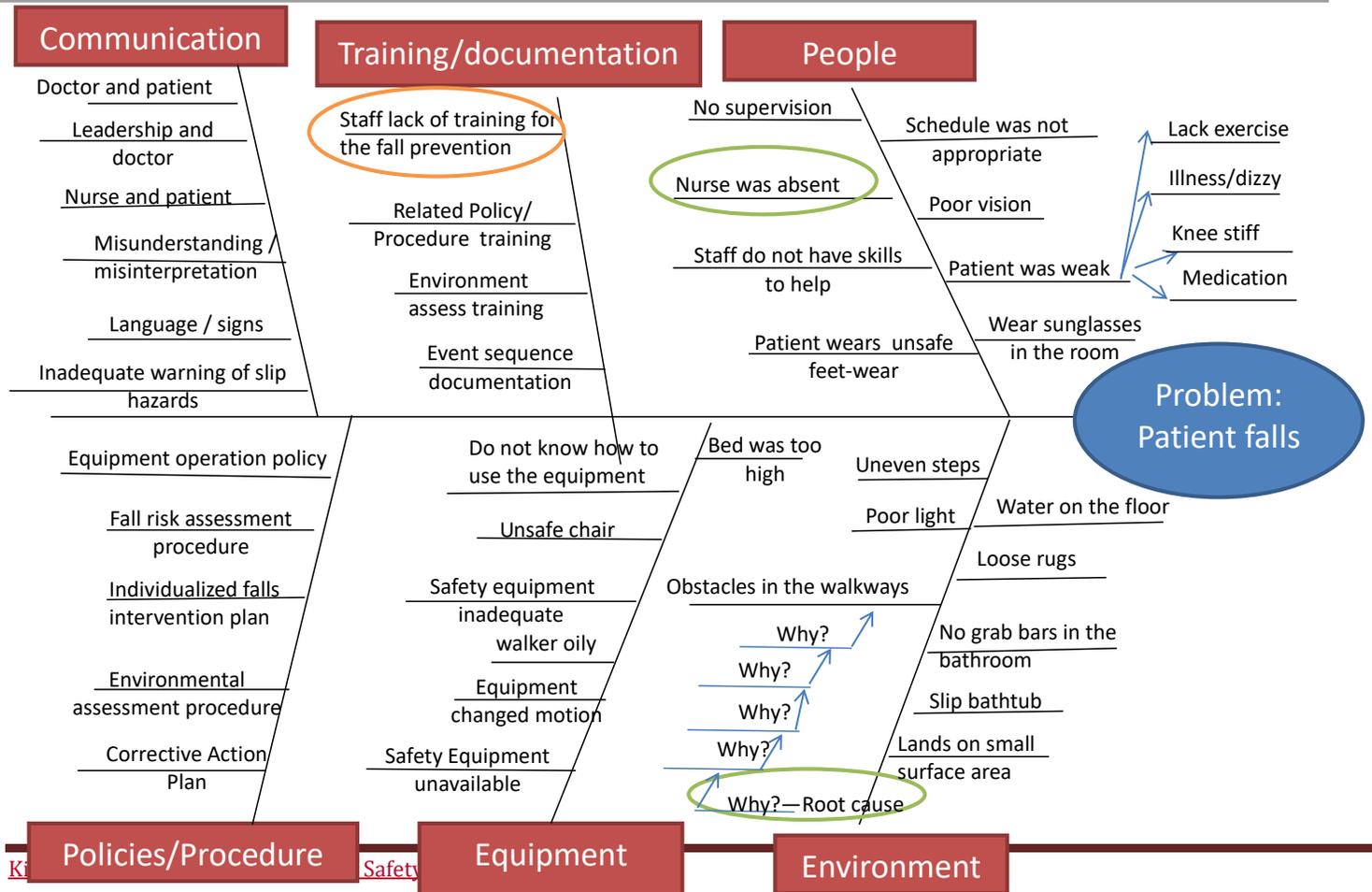
Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
		Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS. Increase number of events reported by 10%. Create process for communicating outcome of reported events.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
		Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans.	Establish & implement a plan to improve performance of each leap.	
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication		Establish Patient Safety Council.	
		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.			

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram

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Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:	
Person Completing Worksheet:	Date:
Telephone/ Email:	Cycle:
Patient Safety Committee Members	
CEOs/CFOs	
Patient Safety Officer	
Infection Control Officer	
Other Medical Staff	
Other team members	
Aim: (Describe the overall SMART goal that your team wishes to achieve.)	
Plan:	
1. List the tasks needed to set up this test of change.	
2. Predict what will happen when the test is carried out.	

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3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

--

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	

<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

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Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			

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Notes:	

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				

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Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient					
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	HOSPITAL POLICY AND INFORMATION MANUAL
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2	Date Issued: 07/01 08/14 Date Last Revised: 08/17 Next Review Date: Approved By: Policy Committee

Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls					
--	--	--	--	--	--

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQUIP5 - 1.5.1 and 1.5.2 Infection Control
- EQUIP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

 HOSPITAL POLICY AND INFORMATION MANUAL	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2		

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- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

Physicians' Surgery Center of Nevada

QUALITY AND PATIENT SAFETY PLAN

DATE:1/28/2019
VERSION: 1



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

Patient Safety Committee
Physicians' Surgery Center of Nevada
3475 G.S. Richards Blvd Suite 110
Carson City, NV 89703
775-885-7726

Contents

Commitment to Patient Safety.....	3
Mission, Vision, and Values	3
Scope and Purpose.....	3
Roles and Responsibilities.....	4
Roles and Responsibilities	5
Objectives and Goals of the Quality and Patient Safety Plan	8
Components and Methods	8
Root Cause Analysis.....	9
Model for Improvement.....	10
Data Collection and Reporting.....	11
Assessment of the Quality and Patient Safety Plan	12
Patient Safety Checklists and Patient Safety Policies	13
Approval of Patient Safety Plan.....	15
Reference.....	15
Appendix A: Terms and Definitions	16
Appendix B: Patient Safety Goals	18
Appendix C: Fishbone Diagram.....	19
Appendix D-1: PDSA Worksheet.....	20
Appendix D-2: PDSA Monthly / Quarterly Progress Report	22
Appendix E: Checklist Example: Injuries from Falls and Immobility.....	23
Appendix F: Policy Example.....	24

Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, Physicians' Surgery Center of Nevada Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in Physicians' Surgery Center of Nevada are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

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

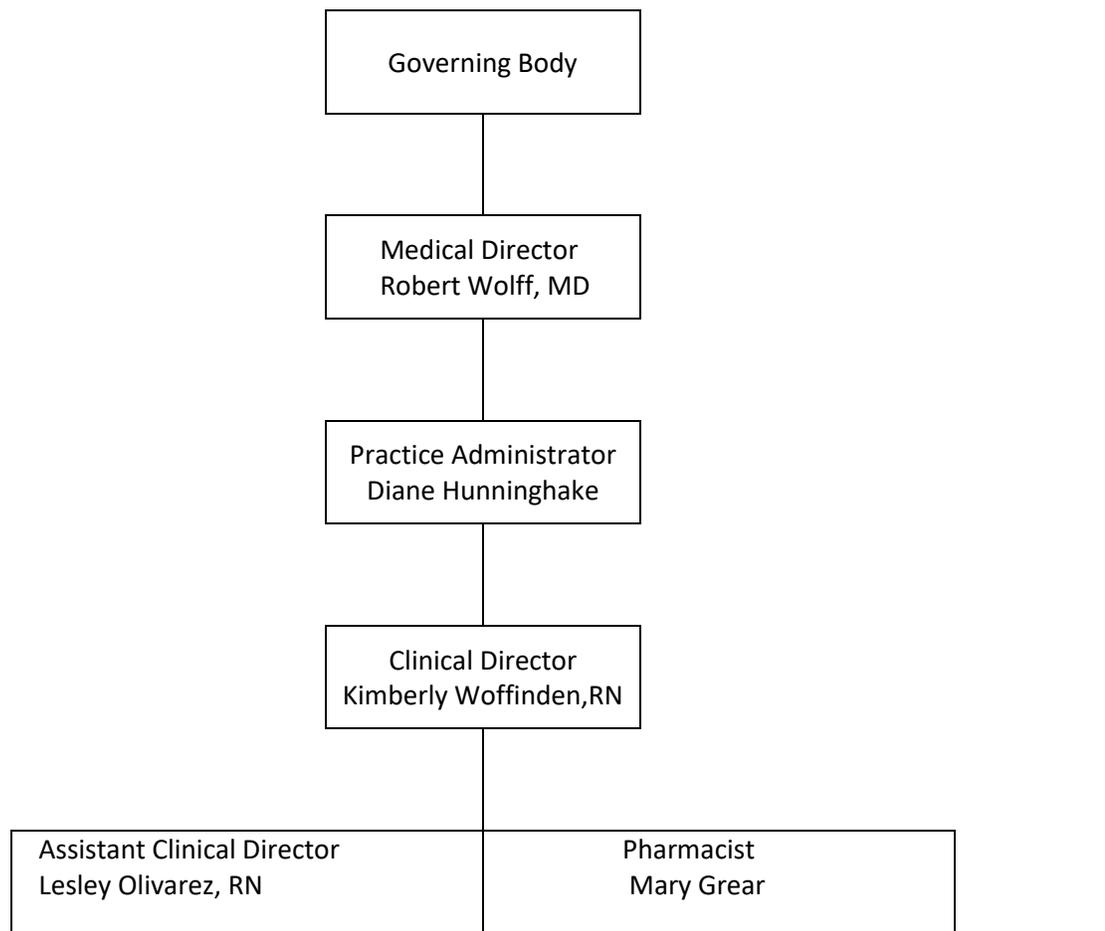
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

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

Roles and Responsibilities

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

The Patient Safety Committee Organization



Roles and Responsibilities

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

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

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

The roles and responsibilities are defined below (Please modify them as needed.)

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

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

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

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

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

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

RCA team leader/facilitator Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.

- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

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

The Patient Safety Committee will meet quarterly to accomplish the following:

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

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

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



Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Physicians' Surgery Center of Nevada to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

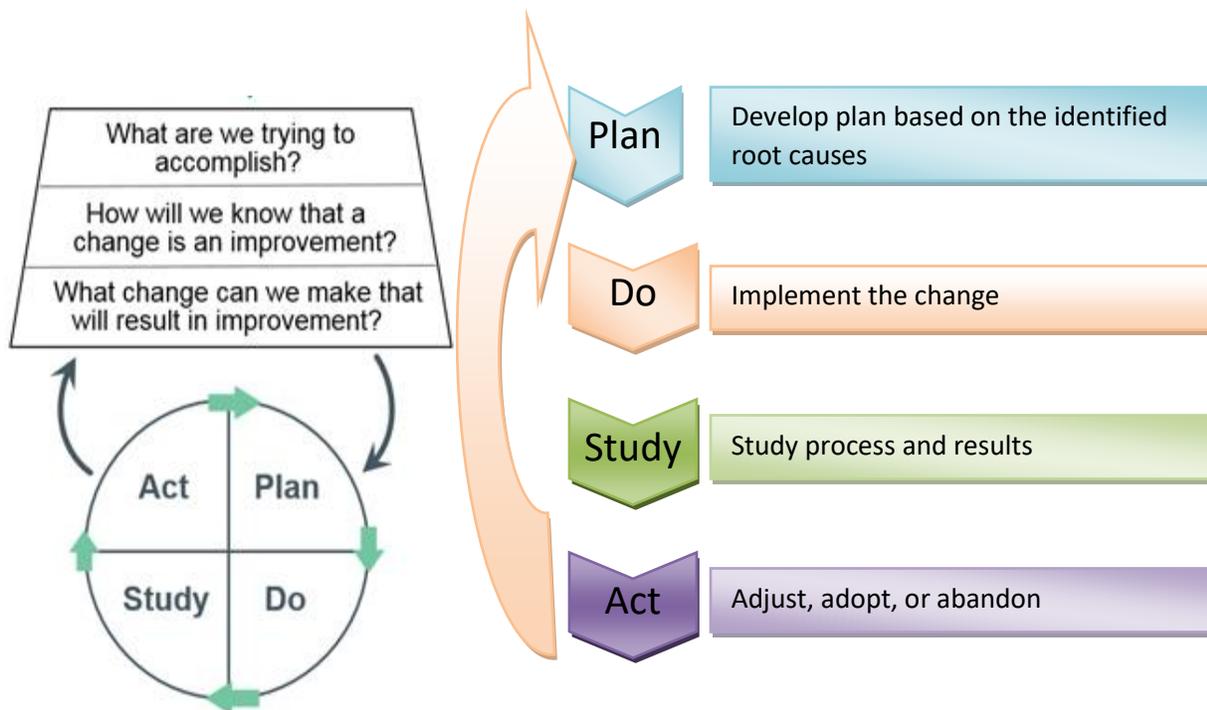
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why's technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.

- What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
 - Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
 - Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Physicians' Surgery Center of Nevada is using Redcap for tracking the sentinel events, healthcare infection data, and for internal data collection.

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

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



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

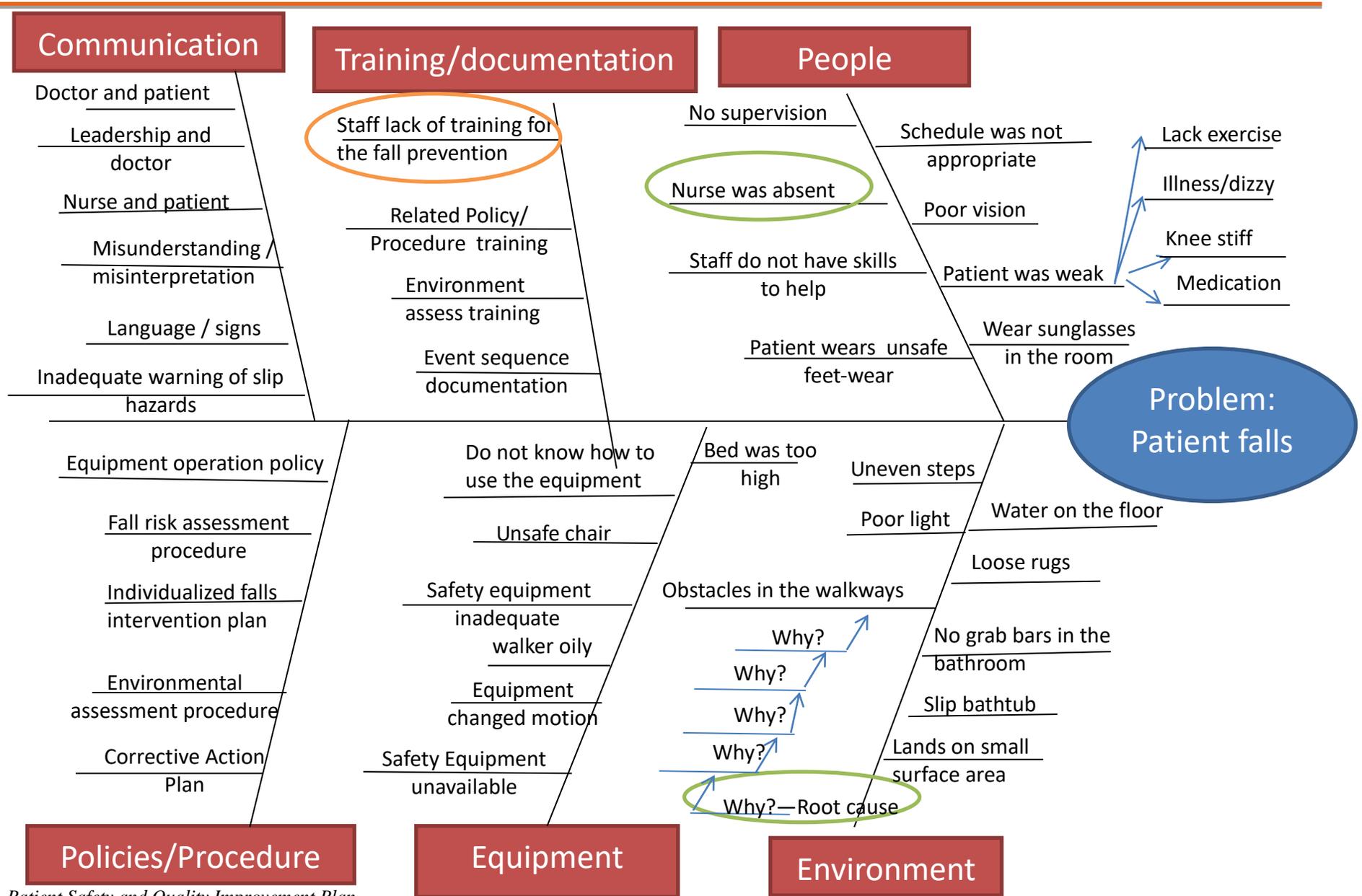
Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process.			Implement Trigger Tools. Develop automated surveillance reports in Cerner.
	b. Establish an automated surveillance process.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS.	
	b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.		Increase number of events reported by 10%.	
	c. Establish a process for providing feedback regarding reported events.		Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.	
	b. Establish a recognition program that rewards safe practices.		Include patient safety presentation in monthly New Employee Orientation.	
	c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Develop 'Great Catch' awards program.	
				Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
	b. Facilitate the development of action plans associated with measures not meeting benchmarks.	Complete 2014 Leapfrog Safety Survey.	Establish & implement a plan to improve performance of each leap.	
	c. Assess and improve processes related to hand-off, transition and communication	Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.		Establish Patient Safety Council.	
	b. Reduce and eliminate variation in care.		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.	
			Revise or develop policies, procedures and protocols.	

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Patient Safety and Quality Improvement Plan

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome
Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			
<input type="checkbox"/> Adopt: expanding changes throughout organization			
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle			

Appendix D-2: PDSA Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>07/01 08/14 08/17 Policy Committee</p>

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

	HOSPITAL POLICY AND INFORMATION MANUAL	
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

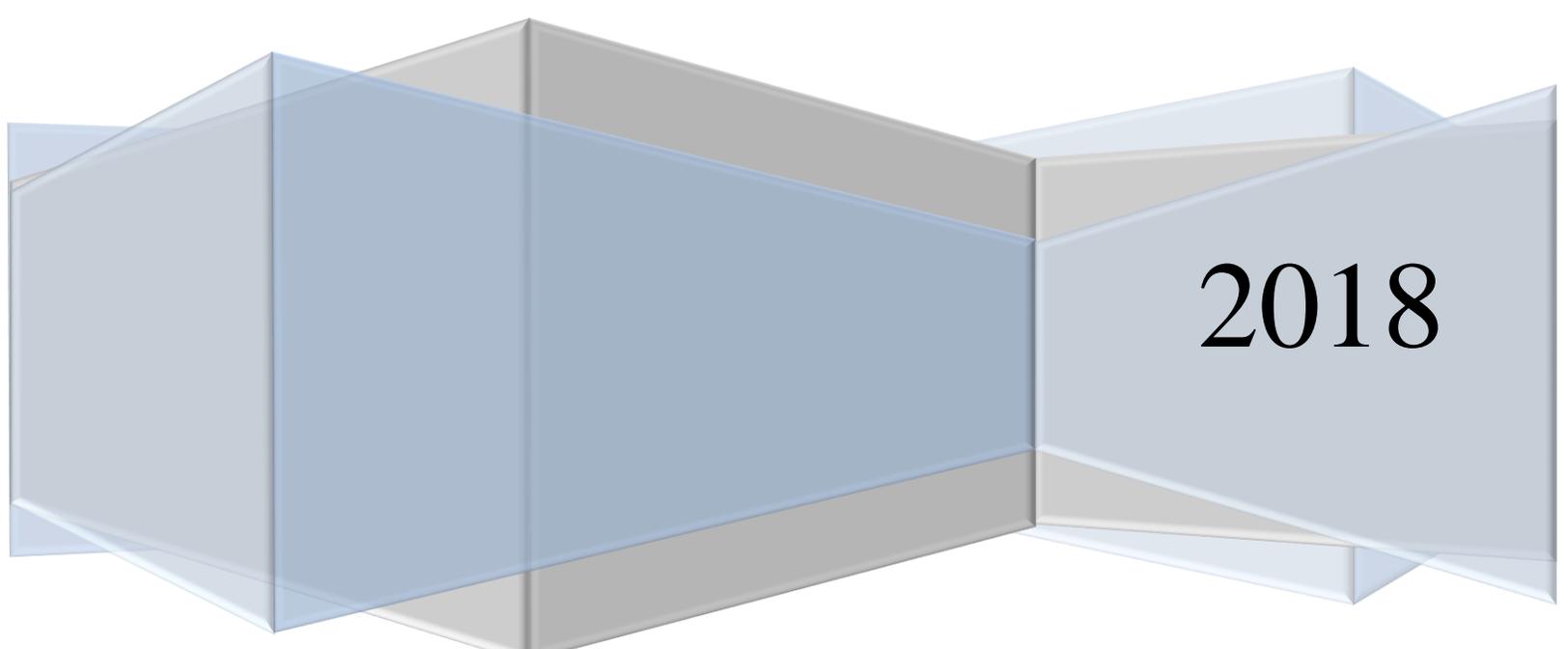
Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

Horizon Specialty Hospitals

Safe Environment Plan

Las Vegas and Henderson



2018

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016, 12/2017

SUBJECT: Safe Environment Plan

**HORIZON SPECIALTY HOSPITALS
HENDERSON/LAS VEGAS**

DEPARTMENT: Plant Operations/Safety

SUBJECT: Safe Environment Plan - 2018

I PURPOSE

The purpose of the Safe Environment Plan is to provide a programmatic framework to reduce the risk to Horizon Specialty Hospitals. The plan includes processes that are designed to evaluate risks that may adversely affect the life or health of patients, staff and visitors.

Mission:

Horizon Specialty Hospitals are committed to providing medically complex and rehabilitative care in a long-term acute care hospital environment to ensure quality care by using goal directed strategies, safe practices and teamwork to achieve optimal outcomes. The safe environment program is designed to support patient safety and effective care by providing reliable information that allows facility management and staff to make better safety decisions and to evaluate key issues and opportunities for improvement of safety performance.

Consistent with this mission, Horizon Specialty Hospitals have established and provides ongoing support for the safe environment program described in this plan.

II SCOPE

The facility has an Environment of Care Committee (EOC) consisting of a cross representation of the facility's staff. The EOC monitors training and competence of staff and assesses conditions of the physical plant, grounds, and equipment through building inspections, environmental rounds, safety inspections and various performance improvement initiatives. Through review of reliable information, management is able to make the best decisions regarding safety concerns and to evaluate safety performance related to key issues with opportunities for improvement. The EOC monitors and evaluates all safety issues. It takes action and makes recommendations to the facility leadership, including the Administrator/Executive Officer, who is a member of the Governing Board. The EOC may issue assignments to committee members and non-committee staff for follow-up actions/improvements and completion of reports.

III FUNDAMENTALS

- A. Safety is information driven. Without appropriate information, accident and incident causing situations cannot be predicted and prevented.
- B. Department managers need appropriate information to develop an understanding of safe working conditions and safe work practices within their area of responsibility.

SUBJECT: Safe Environment Plan

- C. Safe working conditions and practices are established by using knowledge of safety principles to: educate staff, evaluate existing conditions, design appropriate work environments and purchase appropriate equipment and supplies.
- D. The safe environment program establishes processes for identifying, evaluating and alleviating practices or situations that have a potential to harm patients, staff, or visitors or damage to property.
- E. The safe environment program establishes processes to reduce the occurrences, the probability and the effects of person-to-person violence.

IV GOALS

- A. Comply with accepted standards of safety.
- B. Provide a safe, secure and therapeutic environment for patients, staff and visitors.
- C. Integrate safety practices into daily operations.
- D. Identify opportunities to improve performance.

V ORGANIZATION AND RESPONSIBILITY

- A. The Administrator receives regular reports on activities of the safety program from the EOC. The Administrator reviews reports and, as appropriate, communicates safety related concerns about identified issues and regulatory compliance.
- B. The Administrator reviews reports and, as necessary, communicates concerns about key issues and regulatory compliance to appropriate departments, services and staff. The administration collaborates with appropriate departments, services and staff to establish operating and capital budgets for the safe environment program.
- C. The Safety Officer (SO) has responsibility for identification, collection and analysis of information regarding safety deficiencies, development of plans for improvement, accident and injury prevention and investigation, and emergency response. Training of staff and volunteers is facilitated by the Director of Plant Operations.
- D. The EOC coordinates processes within the Environment of Care Standards. Membership on the EOC is by appointment from the Administrator and includes representatives from administration, clinical services and support services. The EOC meets as often as is necessary on a regular basis to receive reports and to conduct reviews of safety issues. Additional meetings may be scheduled at the request of the Safety Officer.

SUBJECT: Safe Environment Plan

- E. The Administrator authorizes key staff to take immediate and appropriate action in the event of an emergency. An emergency is a situation that poses an immediate threat to life or health, or threatens to damage equipment or buildings.
- F. Department managers are responsible for the orientation of new staff members to the department, program and job specific safety procedures.
- G. Individual staff members are responsible for learning and following job and task specific procedures for safe operations. Individual staff members are also responsible for learning and using reporting procedures.

VI PROCESSES OF THE SECURITY PROGRAM

A. Risk Assessment

The Horizon Specialty Hospitals Safety officer is responsible for managing the safe environment program risk assessment process. When issues arise the Safety Officer will consult with the Administrator in regard to approval for actions or guidance.

1. Horizon Specialty Hospitals pro-actively performs risk assessments in a manner that allows for comprehensive evaluation of existing aspects of the organization, and the impact of proposed changes. The goal of risk assessment is to reduce the likelihood of future incidents that have the potential for injury, accident, or other loss to patients, staff, visitors and facility assets.
2. Horizon Specialty Hospitals address other environmental considerations when performing risk assessment functions. For example, when planning demolition, construction, or renovation work, the facility conducts a proactive risk assessment using risk criteria to identify hazards that could potentially compromise patient care in occupied areas of the facility buildings.

Use of the risk assessment process triggers organization linkages with other aspects of the safe environment program. For example, a proposed change may indicate a need to create or revise existing safety policies and procedures; hazard surveillance in the areas affected; safety orientation and education programs; and safety performance improvement monitoring. Horizon Specialty Hospitals' SO is responsible for coordinating the impact of proposed changes with other aspects of the safe environment program.

Horizon Specialty Hospitals' SO and department managers are responsible for performing follow-up activities on issues, findings, observations or recommendations that result from applying the risk assessment process. Horizon Specialty Hospitals' EOC reviews reports related to the safe environment program risk assessment processes.

B. Reporting and Investigating

SUBJECT: Safe Environment Plan

The safe environment program uses a variety of reporting methods to document activities. The SO, Risk Manager, Chief Nursing Officer/Chief Operations Officer (CNO/COO) and Human Resources Director share responsibility for managing, reporting and investigating incidents.

Reports of patient and visitor incidents/accidents are made using the appropriate forms. These reports are reviewed by the EOC, QAPI and Infection Control. Aggregate information is reviewed by the EOC.

Reports of significant property damage are directed to the SO.

One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

C. Hazard Surveillance

The Director of Plant Operations (DOPO) is responsible for managing the hazard surveillance process including product safety recalls. Hazard surveillance surveys are conducted to evaluate staff knowledge and skill, EOC compliance, observe current practices, assess/evaluate environmental conditions and other risk factors. Results of hazard surveillance activities serve to improve safety policies and procedures, risk assessments, orientation and education programs and staff performance.

Surveys are conducted on a frequency that meets the needs and requirements of the various areas that are surveyed. All inpatient care areas are scheduled for at least two annual hazard surveillance surveys. Non-patient care areas are scheduled for at least one hazard surveillance survey each year. Areas or systems under special circumstances are scheduled for additional surveys as required.

Additional hazard surveillance surveys are performed during the application of Interim Life Safety Measures (ILSM). Hazard surveillance surveys to assure free and unobstructed exiting for construction projects are performed daily.

The EOC is responsible for oversight of the hazard surveillance program. This includes ensuring that the information received includes an analysis of data collected, identification of trends and patterns, risk reduction strategies, corrective action recommended or taken and persons responsible.

Individual department managers are responsible for initiating appropriate action on findings applicable to their scope of authority or responsibility. The SO is responsible for coordinating follow-up activities with individual department managers to ensure each finding is brought to closure.

D. Environment of Care Committee

SUBJECT: Safe Environment Plan

The EOC includes selected members of administration, clinical and support services.

The Safety Officer through the EOC is responsible for managing the process of examining safety issues. Effective use of information is dependent on written and verbal reports from a number of different functions within Horizon Specialty Hospital. Reports are used to identify and communicate problems, time-sensitive issues and general information about periodic or structured activities to the EOC. Reports help the EOC to prioritize, develop and approve recommendations for improvement of patient, staff and visitor safety. It is the responsibility of the EOC Chairperson to review the content of reports submitted.

The EOC processes information via a discussion of findings and recommendations outlined in the minutes for each meeting. The minutes also document recommendations the EOC has developed and otherwise approved.

E. Performance Improvement Monitoring

The SO through the EOC has overall responsibility for coordinating the ongoing performance monitoring and the performance improvement monitoring for each of the seven functions associated with Management of the Environment of Care. The SO is responsible for all monitoring associated with the safe environment program.

The intent of establishing performance monitoring is to improve the safe environment program through objective measures of demonstrated performance. **The results of measurement are reported through appropriate channels including the facility's leadership and when appropriate to relevant components of the facility wide patient safety program.** Performance improvement is an important aspect of the Safe Environment Plan. Ongoing performance monitoring serves as an indicator of continued effectiveness of the safe environment program and is a mechanism to identify performance improvement opportunities.

F. Policies and Procedures

The SO has overall responsibility for coordination of the EOC policy and procedure process including coordination with individual department managers.

Individual department, program, and site managers are responsible for their specific safety policy and procedure process. These safety policies and procedures address issues such as: safe operations, use of hazardous equipment or processes and use of personal protective equipment. The SO assists department managers in development of new safety policies and procedures and participates in reviewing existing policies and procedures.

Organization-wide safety policies and procedures are communicated to staff via normal communication channels. Department managers are responsible for distribution of safety policies and procedures and ensuring they are enforced. Each staff member is responsible for knowing and following all safety policies and procedures.

SUBJECT: Safe Environment Plan

Both facility-wide and departmental, program and site safety policies and procedures are reviewed at least every three years. Additional interim reviews are performed on an as needed basis.

Horizon Specialty Hospital has established a procedure for implementing new policies, procedures and practices. Administrative policy determines the form, structure and organization of all policies, procedures and practices.

G. Safety Officer Appointment

The Administrator is responsible for managing the Safety Officer Appointment process.

The Administrator is responsible for selecting a qualified individual who is capable of overseeing the development, implementation and monitoring of the safe environment program. By appointment, the SO is assigned overall operational responsibility for the safe environment program. The SO is made known to all staff through normal communication channels.

The SO is accountable to the Administrator and is guided by a written duty description. For example, the SO reviews changes in law, regulation and standards; assesses the need to make changes to general safety, procedures, training; and performs other activities essential to the implementation of the safe environment program.

The SO directs the integration of environment of care monitoring and response activities into the hospital-wide patient safety program.

H. Immediate Threat Statement

The Administrator is responsible for managing the process for identifying individual(s) who may intervene whenever conditions pose an immediate threat to life or health or threatens damage to equipment or buildings.

To support this process an Immediate Threat Statement is defined in the Situation Response and Crisis Communication Manual. This policy is intended to define authority and responsibility in situations that pose an immediate threat; to the life or health of patients, staff and visitors; or risk major damage to buildings or property. The goal of the Immediate Threat Statement is to identify and mitigate an immediate threat situation before such situation results in loss and to return the facility to normal conditions as quickly as possible.

Key staffs are empowered to intervene immediately and to take appropriate action(s) to mitigate the effects of such situations. Such delegation of authority enables the facility to implement the policy, swiftly and decisively, on a twenty-four hours a day/seven days a week basis.

The Immediate Threat Statement is approved by the Administrator; is revised as necessary and reviewed at least every three years.

SUBJECT: Safe Environment Plan

I. Grounds and Equipment

The DOPO is responsible for managing the facilities grounds and external equipment maintenance processes. The Horizon Specialty Hospital provides patient care, treatment or activities outside of facility buildings. There are patient activities conducted outside of facility buildings that require supervision by facility staff.

The DOPO is responsible for scheduling and performing maintenance to facility's grounds and external equipment. DOPO makes regular rounds of various areas to observe and correct conditions and ensure safety of facility's grounds and external equipment.

Facility grounds includes for example: courtyards, shrubs and trees, sidewalks, roadways, parking lots, lighting, signage and fences. External equipment includes for example: electrical switch gear, transfer switches, and fuel storage. The nature of these types of external equipment is such that limited or infrequent preventive maintenance is required. Corrective maintenance is completed on an as needed basis.

J. Annual Evaluation

The SO has overall responsibility for coordinating the annual evaluation of each of the seven functions associated with management of the Environment of Care. The SO is responsible for completing the annual evaluation of the safe environment program. An evaluation of the program's objectives, scope, performance, effectiveness and the Safe Environment Plan is included in each annual evaluation.

In the completion of the annual evaluation, the SO utilizes a variety of source documents such as policy review and evaluation, incident report summaries, risk assessment activities, meeting minutes and statistical information summaries. In addition, other relevant sources of information are used for the annual evaluation, such as results of monitoring studies, reports from accrediting and certification agencies and goals and objectives. The annual evaluation of the security program is used to further develop educational programs, policies, performance monitoring and improvement.

The annual evaluation is reviewed and approved by the EOC. The annual evaluation is then presented to the Performance Improvement Committee, Executive Management Committee, Medical Executive Committee and Governing Board. Minutes or other means of communications from the Governing Board are received, reviewed and acted upon the by the EOC.

VII WORKER SAFETY

The EOC and Infection Control Committee are responsible for identifying activities to reduce the risk of staff/worker injuries.

A. Reporting and Investigating

The safe environment program uses a variety of reporting methods to document activities. The SO, Risk Manager and Human Resource Director share responsibility for managing,

SUBJECT: Safe Environment Plan

reporting and investigating incidents of injuries, occupational illnesses and accidents. Reports are made using the appropriate forms. This information is reviewed by the EOC, QAPI and Infection Control. Aggregate information is reviewed by the EOC.

One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

B. Orientation and Education

The Director of Plant Operations has overall responsibility for organizing the orientation and education program for each of the seven functions associated with Management of the Environment of Care. Department managers are responsible for assuring the safe environment program orientation and education is implemented.

The Director of Plant Operations is responsible for conducting the general orientation program with current information on general safety processes to new staff members as soon as possible but within 30 days of employment. Every new staff member participates in a general orientation program that includes information related to the safe environment program. Critical Environment of Care information is provided prior to staff being allowed to work independently. The Human Resource Department records attendance for each new staff member who completes the general orientation program. Attendance records are maintained in the Education and Human Resource Department.

Each department manager is responsible for providing their new staff members with safe environment orientation specific to their department. The goal of these orientation programs is to provide new staff members with current job specific safety and hazard information.

All staff members of the facility must participate in mandatory continuing education at least once each year, which includes information specific to the safe environment program. This requirement may be satisfied through completion of a self-learning packet or attendance at a regularly scheduled facility-wide continuing education program. The Human Resource and Education Departments maintains records of all completed training.

Various Departments collaborate with the Facilities Department and individual managers, as appropriate, for developing content and supporting material for general and department specific orientation and continuing education programs. The content and supporting materials utilized are reviewed and revised as necessary.

The Human Resource Department reports information on orientation and continuing education data during the reporting period to the EOC.

VIII SMOKING

Horizon Specialty Hospitals have a policy to reduce the risks to patients who smoke, including possible adverse effects on treatment; risks of passive smoke to others; and risks of fire

SUBJECT: Safe Environment Plan

Patients, staff and visitors are prohibited from smoking in all facility regulated buildings and campus.

**RISK MANAGEMENT PLAN MATRIX
2018**

Identified Loss/Risk Exposure <small>Is this a risk/loss exposure for the facility? Who does it most immediately impact? State as a problem. At what point is there a risk? What is the reason for monitoring?</small>	Severity Assessment <small>1-Insignificant 2-Minor 3-Moderate 4-Major 5-Catastrophic</small>	Likelihood Assessment <small>1-Rare 2-Unlikely 3-Moderate 4-Likely 5-Almost Certain</small>	Loss Exposure Analysis Score <small>Loss/Risk Exposure Range: 1 to 10 Low to High</small>	Preparedness Assessment <small>1-Well-prepared 2-Adequately Prepared 3-Moderately Prepared 4-Poorly Prepared 5-Unprepared</small>	Action Steps to reduce/eliminate the loss/risk exposure	Person (s) Responsible	Targeted Completion Date	Actual Completion Date	Annual Plan Review Date(s)	Person Responsible to Monitor	
A Contractual Liability-Decrease in Service Capacity/Providers											
A1	Facility Fails at Cost Containment w/ affiliation agreements & capacity.	3	3	8	2	a.) Strategic plan development	CEO	01/01/2018	01/01/2018	Quarterly	CEO
A2	Facility fails to check clinicians' licenses to make sure that none have been revoked, suspended or expired.	4	2	10	2	a.) Monthly internal audits of personnel files. b.) Company licensure's checked for expiration dates.	Human Resources	Ongoing	Quarterly 2018	Monthly and Annually	Human Resources
A3	Decrease in Census	4	3	8	2	a.) Admission/Discharge data b.) The ADC will be monitored and addressed.	CEO	Ongoing	Daily	Q1 - 2018 Annual Strategic Plan, Budget and Quarterly Operational Reports to the GB	CEO
A4	Facility background checks on employees	4	1	7	1	a.) Policies- internal audits b.) Employee orientation	Human Resources	Ongoing	N/A	At hire and every 5 years thereafter	Human Resources
A5	Facility fails to check staff needing certifications (CPR/First Aid, etc.) and all other Staff Required training	3	3	4	3	a.) Audit process to check expiration. b.) Provider needs to make required trainings accessible	Human Resources	Ongoing	Ongoing	Q1 - 2017 Annual Review and Revisions to the Staff Development Plan	Human Resources
A6	Facility fails to seek new contracts	4	2	10	2	a.) Attending community meetings/board meetings. b.) Marketing c.) Submitting proposals	CEO	Ongoing	Ongoing	Q1 - 2018 Annual Strategic Plan, Budget and Quarterly Operational Reports to the GB	CEO

**RISK MANAGEMENT PLAN MATRIX
2018**

Identified Loss/Risk Exposure Is this a risk/loss exposure for the facility? Who does it most immediately impact? State as a problem. At what point is there a risk? What is the reason for monitoring?	Severity Assessment 1-Insignificant 2-Minor 3-Moderate 4-Major 5-Catastrophic	Likelihood Assessment 1-Rare 2-Unlikely 3-Moderate 4-Likely 5-Almost Certain	Loss Exposure Analysis Score Loss/Risk Exposure Range: 1 to 10 Low to High	Preparedness Assessment 1-Well-prepared 2-Adequately Prepared 3-Moderately Prepared 4-Poorly Prepared 5-Unprepared	Action Steps to reduce/eliminate the loss/risk exposure	Person (s) Responsible	Targeted Completion Date	Actual Completion Date	Annual Plan Review Date(s)	Person Responsible to Monitor	
B Degregation in Care/Harm to Patients											
B1	Confidentiality breaches (HIPAA w/ contract agencies notes, cl. info) Develop HIPAA process/training, printer, inter-office, hallways, phones)	4	2	10	2	a.) Inform staff of HIPAA Process. b.) Review Confidentiality Policy w/ staff and contractual agencies.	Clinical Director, Human Resources, CEO	Ongoing	Ongoing per plan	Q1 - 2018 Annual Review and Revisions to the Staff Development Plan	Clinical Director Human Resources CEO
B2	Professional boundaries	4	2	7	2	a.) Review and Update the Code of Ethics Policy (as needed) and review with staff. b.) Discussions and monitoring of boundaries with peers. c.) Grievance Policy is in place. d.) Staff Satisfaction Surveys e.) EIPs and Additional Staff Trainings	Clinical Director, Human Resources, CEO	Ongoing	Ongoing	Q1 - 2018 Annual Policy and Procedure Review	Human Resources
C Loss of Funding/Financial Loss											
C1	Changes in funding streams/ contracts	4	3	10	3	a) Develop a reduction in force plan. b) Seek alternative funding opportunities. c) Ensure infrastructure stays intact so organization continues to meet existing objectives.	CEO	Ongoing	Ongoing	Q1- 2018 Annual Strategic Plan, Budget and Quarterly Operational Reports to the GB	CEO
D Facility Liability											
D1	Effective Corporate Compliance	3	2	6	2	a.) Staff training. b.) Report corporate compliance issues to Governing Board	Human Resources	Ongoing	Ongoing	Q1 - 2018 Annual Staff Development Plan Review and Quarterly Reporting to GB	Human Resources
D2	Insurance coverage adequate	4	1	10	2	a.) Review annually for policy changes and coverage amounts.	CEO	Annually	Q1 2018	Q4 Annually via AAC	CEO

**RISK MANAGEMENT PLAN MATRIX
2018**

Identified Loss/Risk Exposure <small>Is this a risk/loss exposure for the facility? Who does it most immediately impact? State as a problem. At what point is there a risk? What is the reason for monitoring?</small>	Severity Assessment <small>1-Insignificant 2-Minor 3-Moderate 4-Major 5-Catastrophic</small>	Likelihood Assessment <small>1-Rare 2-Unlikely 3-Moderate 4-Likely 5-Almost Certain</small>	Loss Exposure Analysis Score <small>Loss/Risk Exposure Range: 1 to 10 Low to High</small>	Preparedness Assessment <small>1-Well-prepared 2-Adequately Prepared 3-Moderately Prepared 4-Poorly Prepared 5-Unprepared</small>	Action Steps to reduce/eliminate the loss/risk exposure	Person (s) Responsible	Targeted Completion Date	Actual Completion Date	Annual Plan Review Date(s)	Person Responsible to Monitor	
D3	Property loss due to fire, natural disasters, or accidents	4	2	7	1	a.) Property contents insurance, general liability insurance b.) AAC keeps backed up data on off site server c.) Server is backed up daily	IT Department, CEO	Ongoing	Ongoing	Q1- 2018 Technical Services Plan Review	Human Resources
E Employee Liability											
E1	Personal safety	2	2	5	1	a.) Safety in the Workplace Staff Development. b.) CPR and First Aid Training. c.) Safety drills held. d.) Notification to staff and patients via telephone e.) Review and revise Health and Safety policies. f.) Recertify fire extinguishers.	Human Resources, CEO, Plant Operations	Ongoing	Ongoing	Q1 - 2018 Annual Policy and Procedure Review Annual Staff Development Plan Review	Human Resources
E2	Retention/Turnover Issues: a.) Burnout/Stress b.) Communication Issues (Complaints and Problems Not Resolved)	2	2	5	1	a.) Burnout/Stress: Supervision. b.) Communication Issues: Address through Strategic Planning/Organizational meetings. b1.) Staff Meetings. b2.) Communication Policy Revision and Staff Awareness. b3.) Staff Review Policy and Procedures annually. b4.) Educate staff on the use of EMR	Human Resources, CEO, Clinical Director	Ongoing	Ongoing	Q1 - 2018 Annual Staff Development Plan Review	Human Resources, Clinical Director, CEO

**RISK MANAGEMENT PLAN MATRIX
2018**

Identified Loss/Risk Exposure <small>Is this a risk/loss exposure for the facility? Who does it most immediately impact? State as a problem. At what point is there a risk? What is the reason for monitoring?</small>	Severity Assessment <small>1-Insignificant 2-Minor 3-Moderate 4-Major 5-Catastrophic</small>	Likelihood Assessment <small>1-Rare 2-Unlikely 3-Moderate 4-Likely 5-Almost Certain</small>	Loss Exposure Analysis Score <small>Loss/Risk Exposure Range: 1 to 10 Low to High</small>	Preparedness Assessment <small>1-Well-prepared 2-Adequately Prepared 3-Moderately Prepared 4-Poorly Prepared 5-Unprepared</small>	Action Steps to reduce/eliminate the loss/risk exposure	Person (s) Responsible	Targeted Completion Date	Actual Completion Date	Annual Plan Review Date(s)	Person Responsible to Monitor	
F Professional Liability											
F1	False innuendoes and accusations	3	2	10	1	a.) Code of Ethics Policy.	Clinical Director Director of Human Resources	Ongoing	Ongoing	Q1- 2018 Annual Policy and Procedure Review	Clinical Director Director of Human Resources
G Property Loss or Damage											
G1	Claims of breach of confidentiality	4	2	10	2	a.) Staff trained on confidentiality issues related to HIPAA and State law. b.) Policies in place. c.) Liability insurance coverage purchased.	CEO Director of Human Resources	Ongoing	Ongoing	Q1 - 2018 Annual Review and Revisions to the Staff Development Plan	CEO Director of Human Resources
G2	Claims of discrimination in hiring/employment practices	4	3	10	1	a.) Ongoing training regarding employment practices. b.) CEO consults with Director of Administrative Services on employment practices.	CEO Director of Human Resources	Ongoing	Ongoing	Q1 - 2018 Annual Review of HR Policies	CEO Director of Human Resources
G3	Theft by employee	3	2	5	2	Safeguards in place regarding: a.) Who can write checks & who can sign checks. b.) Procedures for handling of cash receipts for copays. c.) Handling of petty cash. d.) Strengthen Equipment Inventory Process	CEO	Ongoing	Ongoing	Q1 - 2018 Annual Review of Policies and Procedures	CEO
G4	Claims of employee hurt on the job	3	2	5	2	a.) Workman's Compensation insurance purchased to cover claims. b.) Policies in place regarding incident reporting and safety in the workplace.	CEO Director of Human Resources	Annually	Q1 2018	Q1 - 2018 Annual Review of Policies and Procedures	CEO Director of Human Resources
G5	Claims of abuse of co-workers or patients by employees	3	2	10	2	a.) Safety in the workplace training provided. b.) Training regarding avoidance of potential situations that could result in claims of abuse. c.) Professional Liability insurance	CEO Director of Human Resources	Ongoing	Q1 2018	Q1 - 2018 Annual Review of Policies and Procedures	CEO Director of Human Resources
H Business Interruption											
H1	Keep organization electronically viable	4	3	8	4	a.) Update computer system as needed. b.) Update and maintain electronic medical records	CEO and Medical Records	Ongoing	Ongoing	As needed	CEO

RISK MANAGEMENT PLAN MATRIX 2018

	Identified Loss/Risk Exposure <small>Is this a risk/loss exposure for the facility? Who does it most immediately impact? State as a problem. At what point is there a risk? What is the reason for monitoring?</small>	Severity Assessment <small>1-Insignificant 2-Minor 3-Moderate 4-Major 5-Catastrophic</small>	Likelihood Assessment <small>1-Rare 2-Unlikely 3-Moderate 4-Likely 5-Almost Certain</small>	Loss Exposure Analysis Score <small>Loss/Risk Exposure Range: 1 to 10 Low to High</small>	Preparedness Assessment <small>1-Well-prepared 2-Adequately Prepared 3-Moderately Prepared 4-Poorly Prepared 5-Unprepared</small>	Action Steps to reduce/eliminate the loss/risk exposure	Person (s) Responsible	Targeted Completion Date	Actual Completion Date	Annual Plan Review Date(s)	Person Responsible to Monitor
H2	Develop Strategic Plan approved by Governing Board	4	3	8	3	a.) Develop Written Strategic Plan, inform staff, and approve by Governing Board.	CEO	01/31/2018	Q1 - 2018	Quarterly	CEO
I Loss of Loss Accreditation/Licensure											
I1	Maintain up to date policies and procedures	4	2	10	1	a.) Review and update plans annually	Director of Compliance & Quality Assurance	Ongoing	Ongoing	Q1 - 2018 Policy and Procedures and Plans Review	Director of Compliance & Quality Assurance
I2	Maintain up to date standards and applicable state law requirements	4	3	10	3	a.) Order The Joint Commission standards manual when notified of changes in standards b.) Print up to date state law requirements when notified of changes in state laws	Director of Compliance & Quality Assurance	Ongoing	Ongoing	As needed	Director of Compliance & Quality Assurance

Approved by CEO on _____

Approved by the Governing Board on _____

Reviewed Annually	
CEO	_____
	Date
Governing Board	_____
	Date

<h1>MICOE</h1>	MINIMALLY INVASIVE CENTER OF EXCELLENCE		
	ORIGINAL DATE: January 2013	REVISED DATE: 8/14/17	PAGE NUMBER: 1 of 2
	SUBJECT: SAFETY PROGRAM		NURSE MANAGER: MEDICAL DIRECTOR: Dr. Name Here
POLICY NUMBER: 7.60			

POLICY:

The surgery center maintains a safety program to address the centers environment of care, safety of patients, staff, and others. The safety program is directly linked to the Quality Assurance Performance Improvement Program. The Governing Body has approved the Safety Program.

PROCEDURE:

- A. The safety program processes for the management of identified hazards, potential threats, near misses, and other safety concerns like
 - 1. Adverse Incidents
 - 2. Incidents/Injuries
 - 3. Medication Errors
 - 4. Recalls
 - 5. Fall Prevention
 - 6. Fire Safety/Prevention (see chapter 8 policies for specifics)
- B. Referenced items have their own individualized policies in the policy and procedure manual.
- C. The safety program is supervised by the Quality Assurance Performance Improvement Committee. The DON is designated as the Safety Officer.
- D. The Safety Officer and Administrator will provide education. Staff in-servicing and/or drills are conducted at the center. In-services/drills provide education and training on safety issues to all staff, such as:
 - 1. Disaster and Emergency Drills and/or Fire Prevention/Safety
 - 2. Universal Precautions
 - 3. Sharps Prevention

The center also provides code drills such as:

- 1. Malignant Hyperthermia
- 2. CPR

- E. At time of employment personnel is oriented, provided training and competency (s).
- F. Unique patient identifiers are consistently used throughout care.
- G. Center has policies for anesthesia support, and post-procedural care.
- H. Center has a written emergency and disaster preparedness plan and documentation of requesting to participate on a community level.
- I. Environmental hazards associated with safety are identified and safe practices are established.
- J. Measures are implemented to prevent skin and tissue from injury from chemicals, cleaning solutions, and other hazardous exposure.
- K. Patients are educated about prescribed medical devices and associated protocols and guidelines.
- L. Methods for ensuring food and drink for patient use is stored, served, and disposed of properly
- M. A process to assess and reduce risks associated with physical hazards.
- N. Products including medications and solutions that carry an expiration date are monitored. The center has policies for disposal of expired medications and supplies in accordance with local, state, and federal guidelines.
- O. The center will designate the DON or surgeon if applicable to provide appropriate education to intended operators of newly acquired devices or products to be used in the care of patients. At MINIMALLY INVASIVE CENTER OF EXCELLENCE the Director of Nursing is designated the Safety Program Officer.

Desert Parkway Behavioral HealthCare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 1
	OF: 10
	EFFECTIVE: 12-2-2013
REVIEWED: 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	REVISED:

I. PURPOSE

The purpose of the organizational Patient Safety Plan at the hospital is to improve patient safety and reduce risk to patients through an environment that encourages:

- Integration of safety priorities into all relevant organization processes, functions, services, departments and programs
- Recognition and acknowledgment of risks to patient safety and medical/health care errors
- The initiation of actions to reduce these risks
- The internal and external reporting of what has been found and the actions taken
- A focus on processes and systems, and the reduction of process and system failures through use of failure mode effect analysis
- Minimization of individual blame or retribution for involvement in a medical/health care error
- Organizational learning about medical/health care errors
- Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations
- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to potential or actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at the hospital. The Patient Safety Plan, developed by the interdisciplinary Safety/Environment of Care Committee and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

Desert Parkway Behavioral HealthCare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 2 OF: 10
	EFFECTIVE: 12-2-2013
REVIEWED: 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	REVISED:

II. PATIENT SAFETY PLAN

- Scope of Activities:
 - The scope of the Patient Safety Plan includes ongoing proactive risk assessments, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety.
 - Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis, maybe, but not limited to:
 - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
 - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
 - Any Medication Variance
 - Any Adverse Drug Reaction
 - Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
 - Sentinel Event: The following events as outlined on NQF Serious Reportable Events in Healthcare:
 - Surgical Invasive Procedure Events
 - Product or Device Events

Desert Parkway Behavioral HealthCare Hospital

SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 3 OF: 10
REVIEWED: 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	EFFECTIVE: 12-2-2013
	REVISED:

- Patient Protection Events
- Radiologic Events
- Care Management Events
- Environmental Events
- Potential Criminal Events
- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- Hospital Acquired Conditions (HACs):
 - a. Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, other injuries)
- The scope of the Patient Safety Plan encompasses the patient population, visitors, volunteers and staff (including medical staff). The plan addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:
 - Environment of Care
 - Emergency Management
 - Human Resources
 - Infection Prevention and Control
 - Information Management
 - Leadership
 - Life Safety
 - Medication Management

Desert Parkway Behavioral HealthCare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 4
	OF: 10
REVIEWED: 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	EFFECTIVE: 12-2-2013
	REVISED:

- Medical Staff
- Nursing
- Provision of Care, Treatment and Services
- Performance Improvement
- Record of Care, Treatment and Services
- Rights and Responsibilities of the Individual
- Waived Testing

Methodology:

- The Interdisciplinary Safety/Environment of Care Committee is responsible for the oversight of the Patient Safety Plan. The Safety/Environment of Care Committee Chairperson will have administrative responsibility for the plan, or the Safety/Environment of Care Committee may assign this responsibility to another member of the committee.
- All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Director PI/Risk Management, who will aggregate occurrence information and present a report to the Safety/Environment of Care Committee. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety/Environment of Care Committee will analyze the report information and determine further patient safety activities as appropriate.
- Through review of internal data reports and reports from external sources (including, but not limited to, sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the performance improvement priority criteria grid, the Safety/Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually. All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams). The proactive risk assessment will include:

Desert Parkway Behavioral HealthCare Hospital

SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 5
	OF: 10
	EFFECTIVE: 12-2-2013
REVIEWED: 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	REVISED:

- Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be
- Prioritizing the potential processes breakdowns or failures
 - For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
 - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
 - Test and implement the redesigned process
 - Identify and implement measures of the effectiveness of the redesigned process
 - Implement a strategy for maintaining the effectiveness of the redesigned process over time
- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organizationwide program.
- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:
 - Perform necessary healthcare interventions to protect and support the patient's clinical condition.
 - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others.
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.

Preserve any information related to the error (including physical information). Examples of preservation of medication label for medications administered to the incorrect patient.

Desert Parkway Behavioral HealthCare Hospital

SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 6
	OF: 10
REVIEWED: 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	EFFECTIVE: 12-2-2013
	REVISED:

Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.

- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the occurrence report to the Performance Improvement Department per organizational policy.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his/her supervisor and document the findings on an incident report. The report will be submitted to the Director PI/Risk Management per organizational policy.
- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:
 - No Harm Failures or Errors (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
 - Mild-Moderate Adverse Outcome Failures or Errors (including medication errors/variances) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the PI/Risk Management Department per organizational policy.
 - Medication Variances/errors - the staff member identifying a medication variance/error (no harm and mild-moderate harm) will notify the Pharmacy Department of the event.
 - Adverse Drug Reaction (ADR) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders.

Desert Parkway Behavioral HealthCare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
	PAGE: 7
SECTION 06: LEADERSHIP	OF: 10
	EFFECTIVE: 12-2-2013
REVIEWED: 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	REVISED:

Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report, submitting the report to the PI/Risk Management Department. Staff will complete ADR report and forward to Pharmacy.

- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his/her supervisor and document the findings on an incident report. The report will be submitted to the PI/Risk Management Department per organizational policy.
- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.
- Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an incident report and submit the report to the PI/Risk Department.
- Hospital Acquired Conditions - staff will follow all established protocols, guidelines and policies and procedures. Staff shall complete incident reports for any breaks in technique or policy not followed.

Established organizational policy (such as the Sentinel Event Policy) and/or the Safety/Environment of Care Committee will determine the organizational response to process/system failures and/or medical/health care errors and occurrences. All sentinel events and near miss occurrences will have a root cause analysis conducted. The determination of the Safety/Environment of Care Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:

- Further remedial action activities necessary for identified occurrences
- Proactive occurrence reduction activities
- Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

Desert Parkway Behavioral HealthCare Hospital

SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
	PAGE: 8
SECTION 06: LEADERSHIP	OF: 10
	EFFECTIVE: 12-2-2013
REVIEWED: 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	REVISED:

- An effective Patient Safety Plan cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences. All staff is required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Safety/Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.
- Sentinel Events - staff members involved in a sentinel event occurrence will receive support from the Safety/Environment of Care Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Safety/Environment of Care Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Service Department, Human Resources Department and/or his/her department supervisor.

As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to their accrediting organization. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting the safety or quality of care concern to their accrediting organization.

- On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.
- The Patient Safety Plan includes implementation of the recommendations set forth by the accrediting organization, or identified alternative recommendations defined by this institution, to achieve compliance with established safety standards. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified safety standards.

Desert Parkway Behavioral HealthCare Hospital

SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
	PAGE: 9
SECTION 06: LEADERSHIP	OF: 10
	EFFECTIVE: 12-2-2013
REVIEWED: 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	REVISED:

- The Patient Safety Plan includes an annual survey of staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Safety/Environment of Care Committee will analyze error reporting data submitted through the PI/Risk Management Department for evidence of this information.

Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care.

The Patient Safety Plan includes consideration, at least annually, of data obtained from the organizational Information Management Needs Assessment, which includes information regarding barriers to effective communication among caregivers.

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. Education includes the staff member's right to report any safety or quality of care concerns to the organization's accrediting organization. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.
- Lessons learned from a root cause analysis shall be communicated to staff who provide services or are affected by a patient safety incident
- Patient safety reports from the Safety/Environment of Care Committee will be submitted to the organizational Quality, which exists as the oversight committee for the Safety/Environment of Care Committee. A data report and recordings of meeting minutes will be forwarded to the Quality Committee.

Desert Parkway Behavioral HealthCare Hospital

SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
	PAGE: 10
SECTION 06: LEADERSHIP	OF: 10
	EFFECTIVE: 12-2-2013
REVIEWED: 01/2019, 01/2018, 12/2016, 12/2015, 12/2014	REVISED:

A written Patient Safety Report shall be forwarded to the Governing Body, at a minimum, once per year. Information in the report shall include:

- All system or process failures
- Number and type of sentinel events
- If patients and families were informed of the adverse events
- All actions taken to improve safety, both proactively and in response to actual occurrences
- All results of the analyses related to the adequacy of staffing and actions taken to resolve the identified problem(s)



QUALITY AND PATIENT SAFETY PLAN 2018

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

Patient Safety Committee/Program
Facility name: Sun Valley Surgery Center
4090 N. Martin Luther King Blvd.
N. Las Vegas, NV 89032
P (702) 489-5460
F (877) 752-9402

Table of Contents

Commitment to Patient Safety.....1
 Mission, Vision, and Values1
Scope and Purpose1
Roles and Responsibilities2
 Roles and Responsibilities3
Objectives and Goals of the Quality and Patient Safety Plan6
Components and Methods.....6
 Root Cause Analysis.....7
 Model for Improvement.....8
 Data Collection and Reporting.....9
Assessment of the Quality and Patient Safety Plan.....10
Patient Safety Program11
Approval of Patient Safety Plan.....18
Appendix A: Checklist Example: Injuries from Falls and Immobility21
Appendix B: Root Cause Analysis and Action Plan20

Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, Sun Valley Surgery Center Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

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

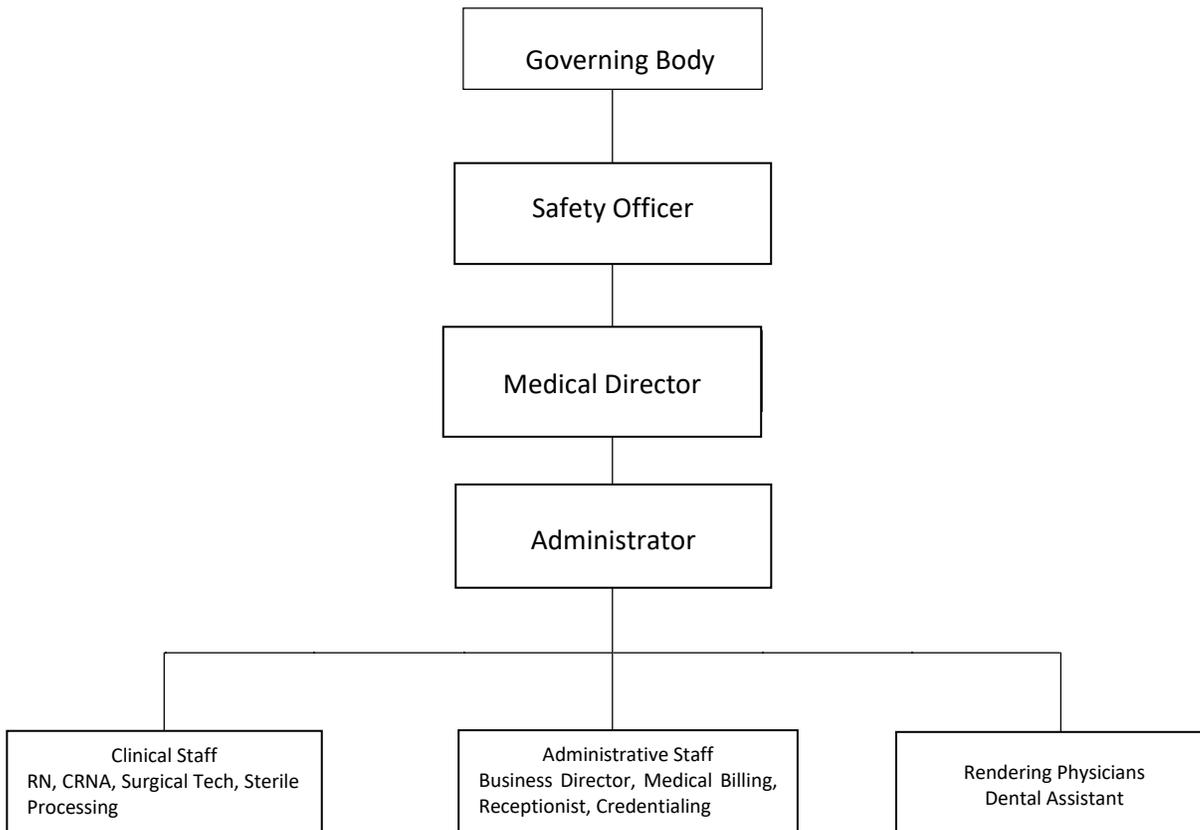
This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Sun Valley Surgery Center has developed this Patient Safety Plan.

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

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

Roles and Responsibilities

The Patient Safety Committee Organization



Roles and Responsibilities

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

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each quarter report to the executive or governing body of the facility regarding.
 - (1) The number of sentinel events that occurred at the medical facility during the preceding quarter.
 - (2) The number and severity of infections that occurred at the facility during the preceding quarter.
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

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

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

RCA Facilitator Responsibilities

- Creating a clear and precise problem definition
- Ensuring that all incident causes are identified and documented in the proper causal relationships
- Encouraging “out of the box” thinking of the team members during the solution identification process
- Summarize the results of the RCA with recommended solutions for submittal to Safety Officer for committee review.

Executive or Governing Body Staff Responsibilities

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

The Patient Safety Committee will meet quarterly to accomplish the following:

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.
A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party

Components and Methods

Pursuant to [NRS 439.837](#) and [NAC 439.917](#), within 45 days after reporting a sentinel event pursuant to [NRS 439.835](#), Sun Valley Surgery Center will conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

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



Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Sun Valley Surgery Center to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

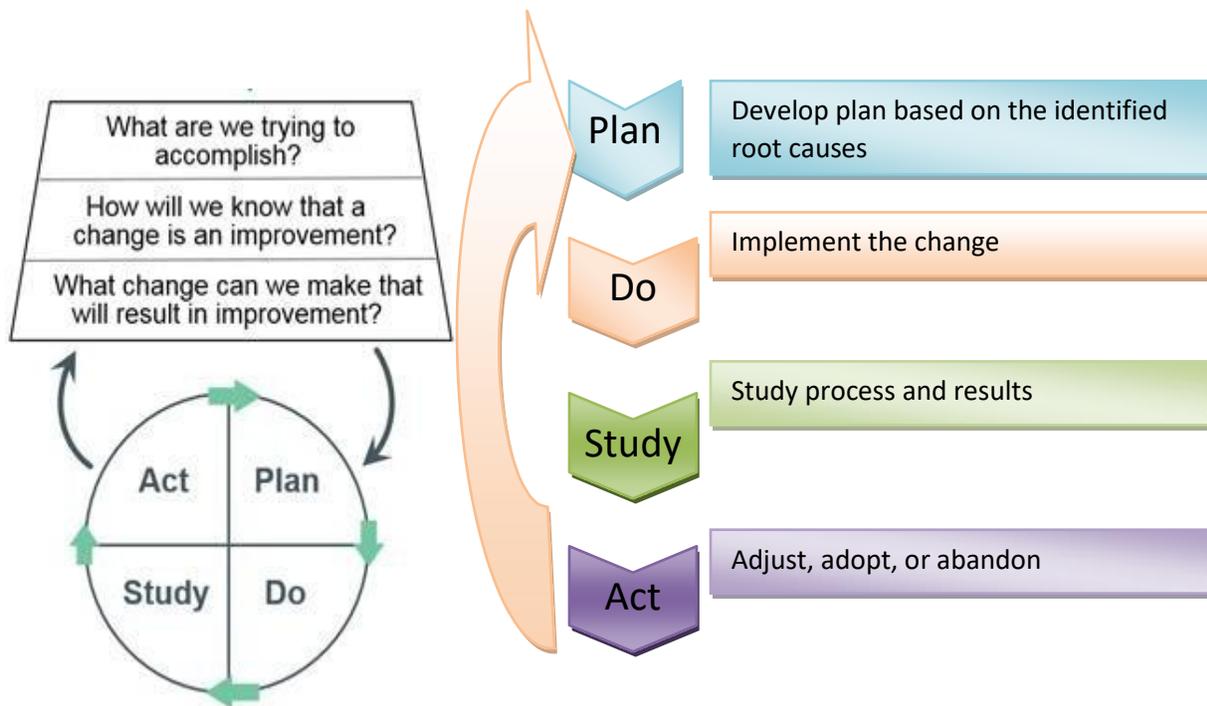
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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



The cycle is defined as follows:

- Plan--Collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
- How will you measure the impact of the test?
- What is your plan to collect the data needed?
- What do you predict will happen?

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

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

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

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Sun Valley Surgery Center is using HST Pathways for tracking the sentinel events, healthcare infection data, and SVSC Audits Spreadsheets for internal data collection.

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

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



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Patient Safety	Sun Valley Surgery Center
Policy Name:	Patient Safety Program

POLICY:

Sedation Dental Center will institute and administer a comprehensive and continuous Patient Safety Program for all patients to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition of risks to patient safety and medical/health care errors
- Actions to reduce these risks
- Internal reporting of incidents and potential incidents and actions taken
- Focus on processes and systems rather than individual blame

PURPOSE:

The Patient Safety Program provides a systematic, coordinated and continuous approach to maintenance and improvement of patient safety by using established mechanisms to support responses to actual occurrences, have an ongoing proactive plan to reduce medical/health errors, and integrate patient safety as a high priority in all relevant organizational processes and services.

RESPONSIBILITY:

As with patient care, it is a coordinated and collaborative effort of the entire organization to maintain and improve patient safety.

The Governing Body approves the data-driven Patient Safety Program and ensures the program reflects the complexity of the facility's organization and services, including those services furnished under contract or arrangement and focuses on the prevention and reduction of medical/health errors and adverse effects.

The Patient Safety Officer is responsible for the management of the Patient Safety Program by:

- Coordinating all patient safety activities
- Facilitating assessment and appropriate responses to reportable events
- Monitoring Root Cause Analysis and resulting action plans

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- Serving as a liaison among the departments to assure facility wide integration of the Patient Safety Program.

Each individual employee within the organization acts as a patient advocate for safety and is responsible to report patient safety occurrences and potential occurrences to the QAPI Coordinator and the Clinical Director, who will aggregate the occurrence information and report to the Governing Body.

PROGRAM:

The scope of the Patient Safety Program includes an ongoing assessment to prevent error occurrence, maintain and improve patient safety.

Patient Safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed to prioritize organizational patient safety efforts.

Types Of Patient Safety Or Medical/Health Care Errors:

- No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
- Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel Event - an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one of the following (even if the outcome was not death or major permanent loss of function):
 - Suicide of a patient.
 - The sexual assault of a patient during treatment or while the patient was on the premises of the facility.
 - A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
 - Medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient.
 - A surgical procedure on the wrong patient or on the wrong body part of a patient.
 - A foreign object accidentally left in a patient during a procedure.
 - A patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
 - Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

What To Do When A Patient Safety Error Occurs

Upon identification of a medical/health care error, the patient care provider will immediately:

- Perform necessary healthcare interventions to protect and support the patient's clinical condition.
- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from supply should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.

- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, piggyback fluid for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
- Report the medical/health care error to the staff member's immediate supervisor.
- Submit the incident occurrence report to the QAPI Committee per organizational policy.

Internal Reporting Of The Error/Event

Staff response to medical/health care errors is dependent upon the type of error identified:

- **No Harm Errors** - (including "no harm medication errors), staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident occurrence report form, submit the form to the QAPI Committee and notify their immediate supervisor.
- **Mild-Moderate Adverse Outcome Errors** (including medication errors), staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts in the medical record and on an incident occurrence report, submitting the report to the QAPI Committee per policy.
- **Adverse Drug Reaction** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts appropriately in the medical record and on an incident occurrence report, submitting the report to QAPI Committee per organizational policy.
- **Transfusion Reaction** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary orders. Staff will then follow the organization policy and procedure for this event.

- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify their supervisor and document the findings on an incident occurrence report which is then submitted to QAPI Committee
- **Sentinel Event** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure, which includes a root cause analysis and action plan.
- **Near Miss** - staff will report the near miss event to their immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to QAPI Committee.
- It is the intent of this facility to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to, their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the individual staff member's supervisor determining the appropriate course of action to prevent error recurrence.

Root Cause Analysis

- All sentinel events and near miss occurrences will have a root cause analysis conducted to examine the cause and effect of the event through an impartial process
- A Root Cause Analysis is an interdisciplinary review process for identifying the basic or contributing causal factors that underlie a variation in performance associated with an adverse event or reportable patient safety event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.
- The QAPI Committee is responsible for conducting the root cause analysis. It will be completed within 45 days of becoming aware of one of the reportable events. They will encourage the staff members' involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution.

A written Root Cause Analysis and "Action Plan" will be created which includes specific measures to correctly identify problems or areas of concern, identify strategies for implementing system improvements; and also includes outcome measures to indicate the effectiveness of system improvements in reducing, controlling or eliminating identified problem areas. The action plan must specifically address responsibility for implementation and oversight, time frames for implementation, and the strategy for measuring the effectiveness of the actions.

- The Joint Commission recommended "A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event" format may be used. See attached.
- Results of the entire Root Cause Analysis will be presented to the Governing Body for evaluation.

Communication of Action Plans and Root Cause Analysis

- Action Plans related to a Root Cause Analysis will be shared with the entire staff upon Completion by the QAPI Committee. Possible recommendations to update or change policy and procedures may be presented to the staff, management and Governing Body to improve patient safety.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. There will be a random record review verifying compliance with this educational process.
- Root Cause Analysis and Action Plans will be made available to the state health department representatives during onsite reviews.

Reporting Obligations

- Medical/Health care errors and occurrences, including sentinel events, will be reported internally and externally, through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

Patient Safety Program Staff Education/Training

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

- Medical errors result from multiple factors. Flawed systems or processes can combine with active failures by caregivers in the clinical setting to produce accidents and errors. Some contributing factors are:
 - Inadequate communication among team members
 - Incomplete review of patient health records and diagnostic studies
 - Traditional hierarchical and autocratic cultures
 - Patient - related decisions made only by physicians
 - Unclear instructions
 - Confusing packaging of medications and supplies
 - Time pressures and constraints, Multi-tasking
 - Failure to include the patient and family members in assessment and decision- making

- Staff will be trained about error reduction, which requires the commitment of all members of the health care team. Besides correcting the identified factors above, the following individual and facility changes will be focused on:
 - Reduce reliance on memory by using checklists and protocols.
 - Standardize processes as much as possible for procedures and other activities.
 - Focus on the safety aspects of products during the selection and evaluation process.
 - Promote safety related clinical competency.
 - Educate employees about the potential for errors and how to avoid them.
 - Creating a "Culture of Safety" whereby there is a change of environment from blaming individuals for errors to one in which errors are treated as opportunities to improve systems. This is accomplished by:
 - o establishing a sense of trust among team members;
 - o dissemination and verifying receipt of information to all levels of staff and management;
 - o developing and supporting a proactive approach rather than a reactive approach;
 - o making a sincere commitment to affirming safety as the first priority.

- Quarterly Patient Safety Program meetings will be incorporated into the QAPI Program and conducted to review any incident occurrence reports and review any new patient safety recommendations or alerts.

Approval of Patient Safety Plan

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

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

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

Appendix A: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks (vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust

Appendix B: Root Cause Analysis and Action Plan

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
What happened?	Sentinel Event	What are the details of the event? (Brief Description)				
		When did the event occur? (Date, day of week, time)				
		What area/service was impacted?				
Why did it happen?	The process or activity in which the event occurred.	What were the steps in the process, as designed? (A flow diagram may be helpful here)				
What were the proximate factors? (typically "special cause" variation)		What steps were involved in (contributed to) the event?				
	Human factors	What human factors were relevant to the outcome?				
	Equipment factors	How did the equipment performance affect the outcome?				
	Controllable environmental factors	What factors directly affected the outcome?				
	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influences this outcome?				
		What other areas of services are impacted?				

The following template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for “root cause” and risk reduction.

As an aid to avoiding “loose ends” the three columns on the right are provided to be checked off for later reference.

- **“Root Cause?”** - should be answered “yes” or “no” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that is relevant to the event is not a root cause, be sure that is addressed later in the analysis with a “why?” question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- **“Ask Why?”** - should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn’t occur when it should have (in other words, to drill down further). Each item checked in this column should be addressed in the analysis with a “Why?” question. If it is expected that any significant finding that are not identified as root causes themselves have “roots.”
- **“Take Action?”** - should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write down the number of the associated Action item on page 3 in the “Take Action?” column for each of the findings that requires action.

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
<p>What happened?</p> <p>Why did that happen? What systems and processes underlie those proximate factors?</p> <p>(common cause variation here may lead to special cause variation in dependent processes)</p>	<p>Human Resources Issues.</p>	<p>To what degree is staff properly qualified and currently competent for their responsibilities?</p>				
		<p>How did actual staffing compare with ideal levels?</p>				
		<p>What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?</p>				
		<p>To what degree is staff performance in the operating process (es) addressed?</p>				
		<p>How can orientation and in-service training be improved?</p>				

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
	Information management issues.	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?				
		To what degree is communication among participants adequate?				
	Environmental management issues.	To what degree was the physical environment appropriate for the processes being carried out?				
		What systems are in place to identify environmental risks?				
		What emergency and failure-mode responses have been planned and tested?				
	Leadership issues: -corporate culture	To what degree is the culture conducive to risk identification and reduction?				
	-encouragement communication	What are the barriers to communication of potential risk factors?				
	- clear communication of priorities	To what degree is the prevention of adverse outcome communicated as a high priority?				
	- uncontrollable factors	What can be done to protect against the effects of these uncontrollable factors?				

Action Plan	Risk Reduction Strategies	Measures of Effectiveness
<p>For each of the findings identified in the analysis as reading an action, indicate the planned action expected, implementation data and associated measure of effectiveness OR</p> <p>-If after consideration of such a finding a description is made not to implement as associated risk reduction strategy, indicate the rationale for not taking action at this time.</p> <p>-Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.</p> <p>-Consider whether pilot testing of a planned improvement should be conducted.</p> <p>-Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.</p>	ACTION ITEM #1	
	ACTION ITEM #2	
	ACTION ITEM #3	
	ACTION ITEM #4	
	ACTION ITEM #5	
	ACTION ITEM #6	
	ACTION ITEM #7	
	ACTION ITEM #8	
<p>Cite any books or journal articles that were considered in developing this analysis and action plans:</p>		

Spring Valley Surgery Center LLC

2018 Sentinel event reporting

3835 S. Jones Blvd. Las Vegas NV 89103 License #: 3421

2705 W. Horizon Ridge Pkwy Henderson NV 89052 License #: 5491

7175 N. Durango Drive Las Vegas NV 89149 License #: 7592

1900 N. Nellis Blvd Las Vegas NV 89115 License #: 7891

1050 E. Sahara Ave Las Vegas NV 89104 License #: 8688

8828 Mohawk Street Las Vegas NV 89139 License #: 8787

Safety committee:

The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the Federal, State, Local and OSHA guidelines. The “Safety Plan” includes identification, evaluation and prevention of workplace hazards relating to the elements and specific criteria. The safety management of the Facility is composed of several elements regarding the safety features necessary for the protection and security of its patients and healthcare workers.

These elements are composed of two parts; one “Life Safety Enterprise Safety Plan” which is wide in scope, organizational and effectiveness, and the “Environmental Safety Management” which oversees the working environment elements of the Facility. These areas overlap each other but also provide individual elements which manage the overall security and safety of the Facility. A report from the Safety Committee is provided quarterly to the Medical Executive Committee (MEC) and onto the Governing Board. The Safety Committee meets and discusses how to improve and/or maintain patient and employee well-being and safety, items discussed range from falls to how to properly lift boxes, and the execution of a disaster drills, etcetera. If any incidents have occurred they will be discussed in detail, and prevention and safety will be implemented.

Facility Name: Nevada Surgical Suites - 8322
Facility Name: Nevada Surgical Suites - 7661

2019 QUALITY AND PATIENT SAFETY PLAN

DATE: 01-23-2019
VERSION: 1.2



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

**Patient Safety Committee/Program
Nevada Surgical Suites**

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702-476-1800

Contents

Commitment to Patient Safety3
 Mission, Vision, and Values3
 Scope and Purpose.....3
 Roles and Responsibilities4
 Roles and Responsibilities4
 Objectives and Goals of the Quality and Patient Safety Plan8
 Components and Methods8
 Root Cause Analysis.....9
 Model for Improvement10
 Data Collection and Reporting.....11
 Assessment of the Quality and Patient Safety Plan12
 Patient Safety Checklists and Patient Safety Policies13
 Approval of Patient Safety Plan15
 Reference.....15
 Appendix A: Terms and Definitions16
 Appendix B: Master Study List.....18
 Appendix C-1: Safety Checklist/Time-Out20
 Appendix C-2: Surgical Handoff21
 Appendix C-3: 10-Element QI Study Template 22
 Appendix D: Policies23

Commitment to Patient Safety

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

Mission, Vision, and Values

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

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

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

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

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

Patient Safety and Quality Improvement Plan

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

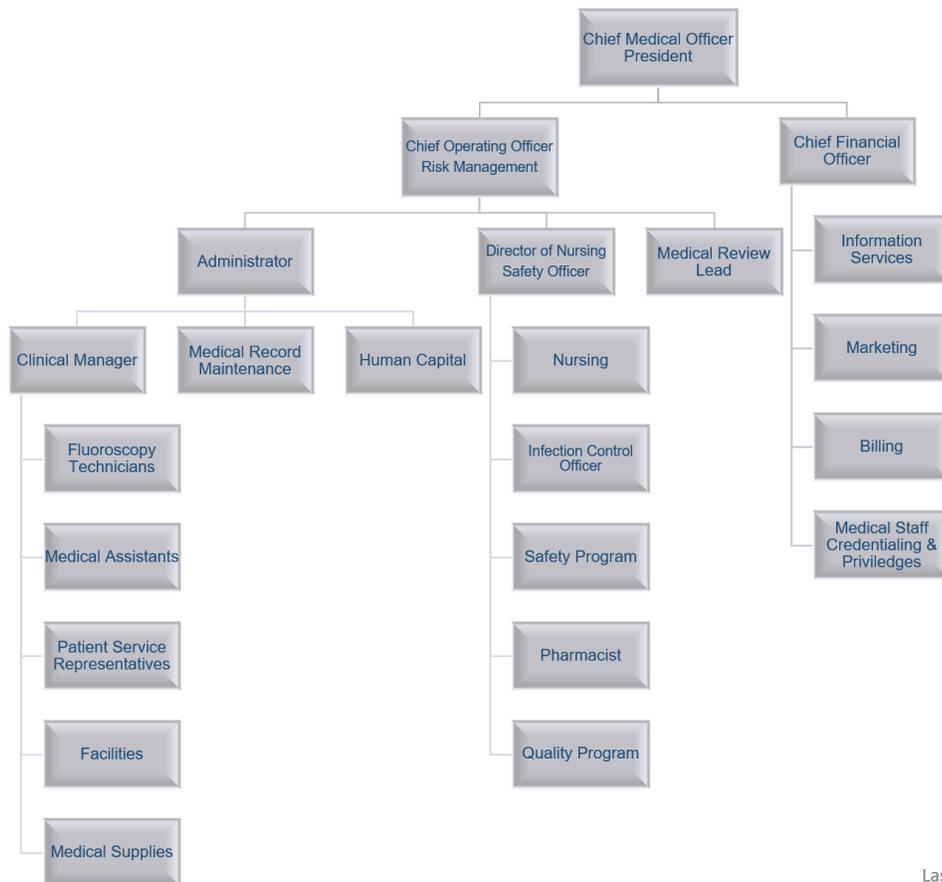
Roles and Responsibilities

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

The Patient Safety Committee Organization



Organizational Chart



Last Revised: 03-01-2018

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:

Patient Safety and Quality Improvement Plan

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

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

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

The roles and responsibilities are defined below:

- Member 1: Medical Provider, Governing Board Member, Executive Team Member
- Member 2: Governing Board Member, Billing Manger
- Member 3: Governing Board Member, Pharmacist
- Member 4: Medical Provider, Governing Board Member, Executive Team Member
- Member 5: Clinical Manager
- Member 6: Chief Financial Officer, Governing Board Member, Executive Team Member
- Member 7: Governing Board Member, Director of Nursing, Infection Control & Safety Officer
- Member 8: Governing Board Member, Administrator

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

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

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

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

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

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

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

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

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

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

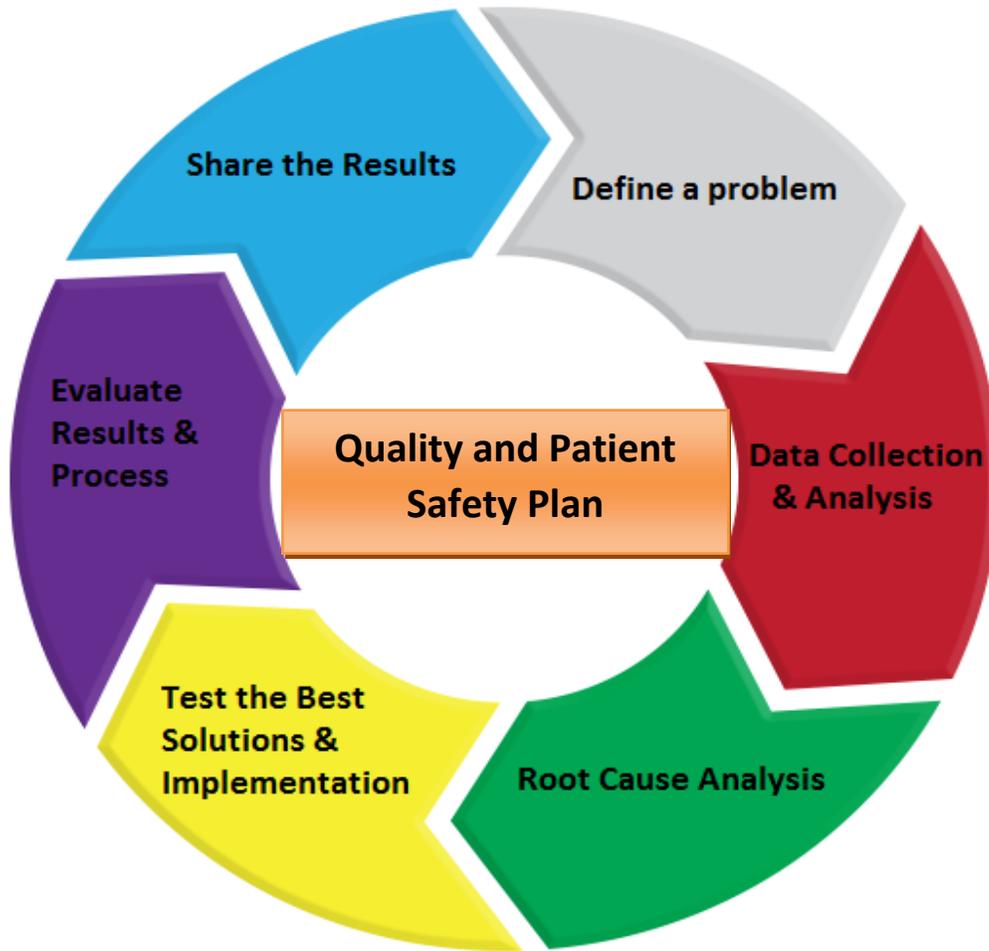
Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Medication Reconciliation	Increase accuracy to ≥ 70%	Increase chart audits with focused training	12-31-2019	Pharmacist
Allergy Documentation	Increase accuracy to ≥ 70%	Continue chart audits with focused training	12-31-2019	Pharmacist
Hand Washing	90% compliance	Observations, training	12-31-2019	Nurse Manager

Components and Methods

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

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



Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Nevada Surgical Suites to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

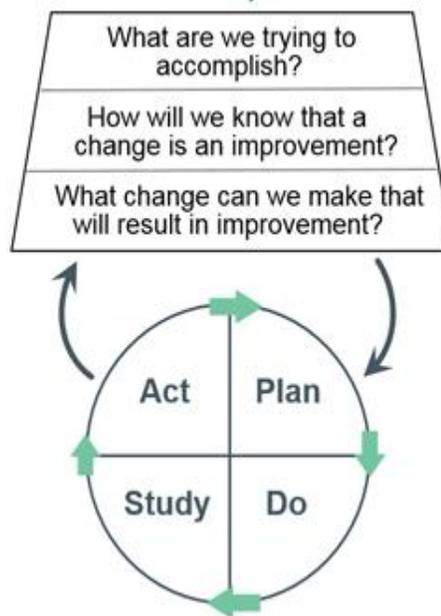
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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



The cycle is defined as follows:

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

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

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

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

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Nevada Surgical Suites is using (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

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

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

- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Quality and Patient Safety Plan is updated annually and submitted through the REDcap Sentinel Event Registry after approval by the organization governing board.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E**.)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.) <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);

- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_ENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Master Study List

Master Study List – Quality Improvement Initiatives

(Infection Control, Patient Safety, Process Improvement)

Calendar Year/ Study Name	Start Date	Completion Date	Re-Assessment Date	Comments	
2015 Study					
1	AAAHC Low Back Injection	01/2015	06/2015	Move to 2016	Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2015	12/2015	Move to 2016	Room for improvement – Study in 2016
3	Handwashing	01/2015	12/2015	Move to 2016	Room for improvement – Study in 2016
2016 Study					
1	AAAHC Low Back Injection	07/2016	12/2016	Move to 2017	Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2016	12/2016	Move to 2017	Room for improvement – Study in 2017
3	Handwashing	01/2016	12/2016	Move to 2017	Performing well – will not study in 2017
2017 Study					
1	AAAHC Low Back Study	04/2017	12/2017	Move to 2018	Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2017	12/2017	Move to 2018	Room for improvement – Study in 2018
3	Q1 2017 ASCA Benchmarking	01/2017	03/2017	Move to Q2	Limited
4	Q2 2017 ASCA Benchmarking	04/2017	06/2017	Move to Q3	Limited
5	Q3 2017 ASCA Benchmarking	07/2017	09/2017	Move to Q4	Limited
6	Q4 2017 ASCA Benchmarking	10/2017	12/2017	Move to 2018	Hold for future reconsideration
2018 Study					
1	Hand Hygiene	01/2018	12/2018	Move to 2019	Room for improvement – Study in 2019
2	AAAHC Low Back Study	01/2018	06/2018	Move to 2019	Evaluating clinical performance measurement and improvement opportunities

3	Medication Reconciliation	01/2018	12/2018	Move to 2019	Room for improvement – Study in 2019
2019 Study					
1	AAAHC Low Back Study	04/2019	12/2019	Planned	Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2019	12/2019	In Progress	Continued improvement need from 2018
3	Handwashing	01/2019	12/2019	In Progress	Continued improvement need from 2018
2020 Study					
1					
2					
3					
4					
5					

Appendix C-1: Safety Check List/ Time-Out



Safety Checklist

Patient:

Area	Done By	Patient or caregiver response
Sedation	<input type="checkbox"/> No Sedation	<input type="checkbox"/> 1. Pt/allergies/procedure confirmed. <input type="checkbox"/> 2. Pt. Verbalizes understanding of anesthesia options. <input type="checkbox"/> 3. Pt. Verbalizes understanding of anesthesia and possible post op pain
Operating Room		<input type="checkbox"/> 1. Pt/allergies/Procedure confirmed. <input type="checkbox"/> 2. Pt. verbalizes adequate understanding of procedure.
<input type="checkbox"/>	Pt. to RN with RN Assistance	<input type="checkbox"/> Ambulates <input type="checkbox"/> Stretcher <input type="checkbox"/> WC
<input type="checkbox"/>	Pt. is positioned upon the O.R. Table and safety strap(s) in use and necessary pillows/cushioning are in place.	<input type="checkbox"/> Prone <input type="checkbox"/> Supine <input type="checkbox"/> R Lateral <input type="checkbox"/> L Lateral
<input type="checkbox"/>	PREP site with:	<input type="checkbox"/> Chloraprep <input type="checkbox"/> Alcohol-prep with No Reaction noted
<input type="checkbox"/>	"TIMEOUT" Conducted to confirm proper patient, procedure, allergies and site	
<input type="checkbox"/>	Procedure Start time:	
<input type="checkbox"/>	Medications injected:	<input type="checkbox"/> Dexamethasone <input type="checkbox"/> Lidocaine <input type="checkbox"/> Marcaine (0.5) (0.25) <input type="checkbox"/> Omnipaque <input type="checkbox"/> Magnevist
<input type="checkbox"/>	Radio Frequency ground pad site:	<input type="checkbox"/> R / L Posterolateral thigh <input type="checkbox"/> R / L posterior thoracic <input type="checkbox"/> R / L Posterolateral buttocks
<input type="checkbox"/>	Radio Frequency Probe(s) Serial Number:	
<input type="checkbox"/>	SCS Trial/Implant Lot Number:	
<input type="checkbox"/>	SCS Trial/Implant Serial Number:	
<input type="checkbox"/>	Pt Tolerated procedure without complications	
<input type="checkbox"/>	Pt Transported via:	<input type="checkbox"/> stretcher (side rails up) <input type="checkbox"/> WC
<input type="checkbox"/>	Procedure End time:	
<input type="checkbox"/>	Pt. transferred to PACU without incident. Time:	

07/20/17 NSS

Appendix C-2: Surgical Handoff



PREPROCEDURE CHECK-IN	SIGN-IN	TIME-OUT	SIGN-OUT
Patient Received by Pre-op RN _____	Patient Received by Intra-op RN _____ Time _____	Time-out _____	Patient received by Post-op RN _____
In Holding Area	Before Induction of Anesthesia	Before Skin Incision	Before the Patient Leaves the Operating Room
Patient/patient representative actively confirms with Registered Nurse (RN): Identity <input type="checkbox"/> Yes Procedure and procedure site <input type="checkbox"/> Yes Consent(s) <input type="checkbox"/> Yes <input type="checkbox"/> N/A Site marked <input type="checkbox"/> Yes <input type="checkbox"/> N/A by person performing the procedure RN confirms presence of: History and physical <input type="checkbox"/> Yes Preanesthesia assessment <input type="checkbox"/> Yes Any special equipment, devices, implants <input type="checkbox"/> Yes <input type="checkbox"/> N/A	RN and anesthesia care provider confirm: Confirmation of: identity, procedure, procedure site and consent(s) <input type="checkbox"/> Yes Site marked <input type="checkbox"/> Yes <input type="checkbox"/> N/A by person performing the procedure Patient allergies <input type="checkbox"/> Yes <input type="checkbox"/> N/A Difficult airway or aspiration risk? <input type="checkbox"/> No <input type="checkbox"/> Yes (preparation confirmed) Anesthesia safety check completed <input type="checkbox"/> Yes Briefing: All members of the team have discussed care plan and addressed concerns <input type="checkbox"/> Yes	Initiated by designated team member All other activities to be suspended (unless a life-threatening emergency) All: Confirmation of the following: identity, procedure, incision site, consent(s) <input type="checkbox"/> Yes Site is marked and visible <input type="checkbox"/> Yes <input type="checkbox"/> N/A Relevant images properly labeled and displayed <input type="checkbox"/> Yes <input type="checkbox"/> N/A Any equipment concerns? Anesthesia Provider: <input type="checkbox"/> Antibiotic prophylaxis before incision <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> Additional concerns? Scrub and circulating nurse: <input type="checkbox"/> Sterilization indicators have been confirmed <input type="checkbox"/> Additional concerns?	RN confirms: Name of operative procedure Any equipment problems to be addressed? <input type="checkbox"/> Yes <input type="checkbox"/> N/A

Surgical Handoff

12/06/2016 NSS

Appendix D: Policies

Chapter 5: Quality and Risk management

Chapter 7 Sub-Chapter 1 & 2: Infection Control and Safety

Chapter 8: Emergency Preparedness



OVERVIEW

The General Safety Program has been created to provide and maintain a safe and healthy environment for all staff members, patients and visitors.

SCOPE & RELEVANCY

- A. The program has been designed to prevent or diminish accidents injuries and illnesses in the workplace. The personal safety and health of all visitors, patients and employees of the Center is of utmost importance.

DEFINITIONS

- A. CENTER means Warm Springs Surgical Center.

DUTIES OF KEY MEMBERS

A. ADMINISTRATOR

- a. The objective of the Administrator is to promote a safe, healthy environment throughout the Center. They are responsible for the overall implementation and maintenance of the Center's Injury and Illness Prevention Program. Duties include, but are not limited to:
 1. Education of all Managers on workplace safety and make them aware of potential workplace hazards to their employees.
 2. Monitoring compliance with training requirements of the program.
 3. Inspecting, recognizing, and evaluating workplace hazards on a continual basis.
 4. Developing and implementing methods for diminishing workplace hazards.
 5. Monitoring hazards to ensure they are taken care of in a timely manner.

B. MANAGERS

- a. Each manager is responsible for developing within themselves and their employees a positive attitude toward safety. Managers must be familiar with workplace hazards associated with the scope of their employees.

C. EMPLOYEES

- a. All employees are responsible for knowing policies and procedures as well as working safely and maintaining a safe and healthful work environment.

HAZARD ASSESSMENT

A. ENVIRONMENTAL SAFETY

- a. Each patient area is surveyed at least every 6 months. Other areas that may have a greater potential of a hazard are surveyed three times annually. All hazards are identified and corrective action is documented and enforced. Immediate hazards are corrected at the time they are noted; all others as soon as possible, no later than 15 days of discovery. Safety Committee may make unannounced rounds within any area of the Center. These rounds will focus on injury and illness hazards which may need further monitoring. Hazard communications, emergency preparedness, work place hazards and safety training audits will be conducted annually.

B. NEW MATTERS



Warm Springs Surgical Center GENERAL SAFETY PROGRAM

- a. The administrator will arrange for the inspection and investigation of any new substances, process, procedure or equipment that is introduced into the facility. This will to evaluate any potential occupational hazards the matter may contain.

C. HOUSEKEEPING

- a. Good housekeeping practices are an essential part of any effective safety program. Keeping the work area clean and neat reduces the risk of injury or accidents. To increase the ability of the workers to perform their jobs more efficiently, well organized work areas are encouraged. Each employee is responsible for their work area, keeping it neat and tidy. Managers are to make housekeeping rounds to ensure compliance.
- b. Immediately Report the following:
 1. Wet or Slippery Floors
 2. Equipment or furniture left in the halls or obstructing an entrance or exit
 3. Storage or use of combustibles near an open flame
 4. Improper storage of hazardous waste.

D. HAZARD REPORTING BY EMPLOYEES

- a. It is the responsibility of all employees to report any unsafe act or condition in their work environment.
- b. Immediately Report the following:
 1. Areas that may be Poorly Lit
 2. Unattended Children
 3. Defective Equipment
 4. Smoking on the Premises
 5. Careless Handling of the Equipment
- c. There will be no disciplinary action resulting from reporting an unsafe condition. Employees do have the option to remain anonymous when filing a report.

E. IMMEDIATE HAZARDS

- a. It the is the intent of the Center to abate all hazards once they have been identified. When such a hazard is present and it cannot be resolved immediately, all employees, patients and visitors will be vacated from the area until the hazard can be addressed.

F. DOCUMENTATION

- a. All rounds will be documented by the Safety Officer. They will be maintained for a period of at least three (3) years. They will include the name of the Person conducting the rounds, the areas examined, date of the rounds, if any hazards were identified, recommended corrective action. Course taken, date of compliance and signature of manager overseeing the actions.

EMERGENCY ACTION PLAN

- A. Warm Springs Surgical Center has put into place a Disaster Plan. This is available to all employees. It is kept in the Administrator's office in the binder under EMERGENCY PLAN.

POLICIES & PROCEDURES FOR SAFETY

- A. Safety polices have been developed and implemented to address the issues that apply to all employees. The policies and procedures for safety are kept in the Administrator's office in the OSHA binder under GENERAL SAFETY. It is available to all employees. The need for changes to the safety policies and procedures are reviewed regularly.



- A. General communication for changes or modifications will be a posting on the bulletin board in the break room and annually during the safety meetings.

ENFORCEMENT

- A. Enforcement of all safety policies and procedures is the responsibility of the Managers. Compliance is mandatory and any violation of this program could result in progressive disciplinary action.

TRAINING

- A. Awareness of potential health and safety hazards is critical to maintaining a safe work environment and to avoid injuries, illnesses and accidents in the work place. Warm Springs Surgical center is dedicated to instruction all employees in health and safe work practices. To achieve this goal, the Center will provide training to each employee with regard to the general safety programs.
- B. TRAINING SCHEDULES
 - a. All new employees will receive a general safety orientation according the Human Resource's policy.
 - b. Employees will receive appropriate safety training upon receiving a new assignment they are unfamiliar with.
 - c. An annual safety in-service will be conducted.
 - d. Additional training will be required if re-enforcement is needed.
- C. TRAINING OF MANAGERS
 - a. It is the responsibility of Managers to be aware of potential health or safety hazards within their deposit. Annual safety program reviews will be conducted with the Administrator. All training records will be kept for a minimum of three (3) years.

ACCIDENT INVESTIGATION

- A. Policy
 - a. All occupational injuries and illnesses must be reported in a timely manner. Upon receipt of the incident report, the Administrator will start an investigation.
- B. Responsibility & procedure
 - a. Employee is responsible for reporting an occupational injury or illness to the Manager and the Administrator will start an investigation as outlined in the Human Resource Workman's Compensation Policy.

CORRECTIVE ACTION

- A. All hazards are to be identified and corrective action taken as soon as possible to avoid re- occurrence of the same injury. Manager is responsible for compliance to correct the problem. All personal involved in correcting the hazardous condition will receive appropriate training on how to do so and will be provided with the necessary PPE and safeguards.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 1 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED: 1/15/2018

PURPOSE:

- The purpose of the Organizational Patient Safety Plan at 215 Surgery Center is to improve patient safety and reduce risk to patients through an environment that encourages:
 - Recognition and acknowledgment of risks to patient safety and medical/health care errors;
 - The initiation of actions to reduce these risks;
 - The internal reporting of what has been found and the actions taken;
 - A focus on processes and systems;
 - Minimization of individual blame or retribution for involvement in a medical/health care error;
 - Organizational learning about medical/health care errors;
 - Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations.
- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at 215 Surgery Center. The Patient Safety Plan, developed by the interdisciplinary Safety Committee and approved by the medical staff, Board of Managers and administration, outlines the components of the organizational Patient Safety Program.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 2 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED: 1/15/2018

PATIENT SAFETY PROGRAM:

- Scope of Activities:
 - The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety. Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:
 - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
 - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
 - Any Medication Error
 - Any Adverse Drug Reaction
 - Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
 - Sentinel Event – as defined in Appendix A of the National Quality Forum Serious Reportable Events in Health-Care-2011 Update: A Consensus Report
 - ◆ The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 3 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED: 1/15/2018

- ◆ The event is one of the following (even if the outcome was not death or major permanent loss of function):
 - Rape (by another patient, visitor or staff)
 - Surgery on the incorrect patient or incorrect body part
 - Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important facility and patient care functions of:
 - Patient Rights
 - Assessment of Patients
 - Care of Patients
 - Patient/Family Education
 - Continuum of Care
 - Leadership
 - Improving Organization Performance
 - Management of Information
 - Management of Human Resources
 - Surveillance, Prevention and Control of Infection
- Methodology:
 - The Interdisciplinary Safety Committee is responsible for the oversight of the Patient Safety Program. The Safety Officer will have administrative responsibility for the

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 4 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED: 1/15/2018

program, or the Safety Committee may assign this responsibility to another member of the committee.

- **All departments** within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Safety Officer, who will aggregate occurrence information and present a report to the Safety Committee on a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety Committee will analyze the report information and determine further patient safety activities as appropriate.
- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organizationwide program.
- Upon identification of a medical/health care error, the patient care provider will immediately:
 - Perform necessary healthcare interventions to protect and support the patient's clinical condition.
 - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
 - Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
 - Report the medical/health care error to the staff member's immediate supervisor.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 5 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED: 1/15/2018

- Submit the occurrence report to the designated individual or committee per organizational policy.
- Any individual in any department identifying a potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Quality Assurance Committee per organizational policy
- Staff response to medical/health care errors is dependent upon the type of error identified:
 - No harm errors - (including “no harm” medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
 - Mild-Moderate Adverse Outcome Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Performance Improvement Department per organizational policy.
 - ◆ Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Services Department of the event.
 - Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Performance Improvement Department per organizational policy. Staff will also notify the Pharmacy Services Department.
 - Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 6 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED: 1/15/2018

immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Performance Improvement Department per organizational policy.

- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.
 - Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to the Performance Improvement Department.
- Established organizational policy (such as the Sentinel Event Policy) and/or the Safety Committee will determine the organizational response to medical/health care errors and occurrences. All sentinel events and near miss occurrences will have a root cause analysis conducted. The determination of the Safety Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
 - Further remedial action activities necessary for identified occurrences
 - Proactive occurrence reduction activities
 - Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities
- An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Safety Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence
 - Sentinel Events - staff members involved in a sentinel event occurrence will receive support from the Safety Committee regarding the staff member's

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 7 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED: 1/15/2018

professional and emotional reconciliation of the sentinel event. The Safety Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from his or her department supervisor.

- On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.
- The Patient Safety Program includes a quarterly survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Safety Committee will analyze error reporting data for evidence of this information.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care.
- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per facility policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.
- A quarterly patient safety report will be forwarded to the Board of Managers on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.



Mountain's Edge Hospital

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN

ORGANIZATIONWIDE

Reference #1502

Page 1 of 12

All approval information is stored in the Online Policy Manager. A hard copy may be found in Administration at any time.

PURPOSE:

- The purpose of the organizational Patient Safety Plan at Mountain's Edge Hospital is to improve patient safety and reduce risk to patients through an environment that encourages:
 - Integration of safety priorities into all relevant organization processes, functions, services, departments and programs
 - Recognition and acknowledgment of risks to patient safety and medical/health care errors
 - The initiation of actions to reduce these risks
 - The internal and external reporting of what has been found and the actions taken
 - A focus on processes and systems, and the reduction of process and system failures through use of failure mode effect analysis
 - Minimization of individual blame or retribution for involvement in a medical/health care error
 - Organizational learning about medical/health care errors
 - Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations
- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to potential or actual incidents; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.



Mountain's Edge Hospital

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN

ORGANIZATIONWIDE

Reference #1502

Page 2 of 12

All approval information is stored in the Online Policy Manager. A hard copy may be found in Administration at any time.

- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Mountain's Edge Hospital. The Patient Safety Plan, developed by the interdisciplinary Environment of Care Committee and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PROGRAM:

- Scope of Activities:
 - The scope of the Patient Safety Program includes ongoing proactive risk assessments, using internal and external knowledge and experience, to prevent error incident, maintain and improve patient safety.
 - One high-risk process shall be selected at least every 18 months and a proactive risk assessment shall be performed.
 - Patient safety incident information from aggregated data reports and individual incident reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:
 - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
 - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
 - Any Medication Error
 - Any Adverse Drug Reaction
 - Any Transfusion Reaction



Mountain's Edge Hospital

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN

ORGANIZATIONWIDE

Reference #1502

Page 3 of 12

All approval information is stored in the Online Policy Manager. A hard copy may be found in Administration at any time.

- Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel Event - an unexpected event or incident involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. (Refer to the Sentinel Event Policy - #1507)
- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- Hospital Acquired Conditions (HACs), (those in accordance with Mountain's Edge Hospital Scope of Services):
 - ◆ Serious preventable event - object left in surgery (never event)
 - ◆ Serious preventable event - air embolism (never event)
 - ◆ Serious preventable event - blood incompatibility (never event)
 - ◆ Catheter-associated urinary tract infections
 - ◆ Pressure ulcers
 - ◆ Vascular catheter-associated infection
 - ◆ Surgical site infection
 - ◆ Surgical site infections following certain elective procedures, including certain orthopedic surgeries and bariatric surgery
 - ◆ Patient falls (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)



Reference #1502

Page 4 of 12

Mountain's Edge Hospital

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN

ORGANIZATIONWIDE

All approval information is stored in the Online Policy Manager. A hard copy may be found in Administration at any time.

- ◆ Manifestations of poor control of blood sugar levels, such as diabetic ketoacidosis, hypoglycemic coma
- ◆ Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures
- The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:
 - Environment of Care
 - Emergency Management
 - Human Resources
 - Infection Prevention and Control
 - Information Management
 - Leadership
 - Life Safety
 - Medication Management
 - Medical Staff
 - Nursing
 - Provision of Care, Treatment and Services
 - Performance Improvement
 - Record of Care, Treatment and Services
 - Rights and Responsibilities of the Individual



Mountain's Edge Hospital

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN

ORGANIZATIONWIDE

Reference #1502

Page 5 of 12

All approval information is stored in the Online Policy Manager. A hard copy may be found in Administration at any time.

- Waived Testing
- Methodology:
 - The Interdisciplinary Environment of Care Committee is responsible for the oversight of the Patient Safety Program. The Environment of Care Committee Chairperson will have administrative responsibility for the program, or the Environment of Care Committee may assign this responsibility to another member of the committee (such as the Performance Improvement Director or Risk Manager).
 - **All departments** within the organization (patient care and non-patient care departments) are responsible to report patient safety incidents and potential incidents to the Performance Improvement Director, who will aggregate incident information and present a report to the Environment of Care Committee on a monthly basis. The report will contain aggregated information related to type of incident, severity of incident, number/type of incidents per department, incident impact on the patient, remedial actions taken, and patient outcome. The Environment of Care Committee will analyze the report information and determine further patient safety activities as appropriate.
 - Through review of internal data reports and reports from external sources (including, but not limited to, The Joint Commission sentinel event report information, ORYX and Core Measure performance data, incident reporting information from state and federal sources and current literature), and through the performance improvement priority criteria grid, the Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually. All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams). The proactive risk assessment will include:
 - Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be
 - Prioritizing the potential processes breakdowns or failures



Mountain's Edge Hospital

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN

ORGANIZATIONWIDE

Reference #1502

Page 6 of 12

All approval information is stored in the Online Policy Manager. A hard copy may be found in Administration at any time.

- For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
- Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
- Test and implement the redesigned process
- Identify and implement measures of the effectiveness of the redesigned process
- Implement a strategy for maintaining the effectiveness of the redesigned process over time
- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organization wide program.
- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:
 - Perform necessary healthcare interventions to protect and support the patient's clinical condition.
 - As appropriate to the incident, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
 - Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications



Mountain's Edge Hospital

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN

ORGANIZATIONWIDE

Reference #1502

Page 7 of 12

All approval information is stored in the Online Policy Manager. A hard copy may be found in Administration at any time.

administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an incident report, and in the medical record as appropriate to organizational policy and procedure.

- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the incident report to the Performance Improvement Department per organizational policy.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings on an incident report. The incident report will be submitted to the Performance Improvement Department per organizational policy.
- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:
 - No Harm Failures or Errors (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
 - Mild-Moderate Adverse Outcome Failures or Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an incident report - submitting the report to the Performance Improvement Department per organizational policy.
 - ◆ Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will notify their supervisor and the Pharmacy Department of the event.
 - Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for



Mountain's Edge Hospital

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN

ORGANIZATIONWIDE

Reference #1502

Page 8 of 12

All approval information is stored in the Online Policy Manager. A hard copy may be found in Administration at any time.

the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an incident report, submitting the report to the Performance Improvement Department per organizational policy. Staff will also notify the Pharmacy Department.

- Transfusion Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the Blood/Blood Component Transfusion Reaction Policy and Procedure.
- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor and document the findings on an incident report. The incident report will be submitted to the Performance Improvement Department per organizational policy.
- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.
- Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an incident report and submit the report to the Performance Improvement Department.
- Hospital Acquired Conditions - staff will follow all established protocols, guidelines and policies and procedures. Staff shall complete incident reports for any breaks in technique or policy not followed.
- Established organizational policy (such as the Sentinel Event Policy) and/or the Environment of Care Committee will determine the organizational response to process/system failures and/or medical/health care errors and incidents. All sentinel events and near miss incidents will have a root cause analysis conducted. The determination of the Environment of Care Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:



Mountain's Edge Hospital

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN

ORGANIZATIONWIDE

Reference #1502

Page 9 of 12

All approval information is stored in the Online Policy Manager. A hard copy may be found in Administration at any time.

- Further remedial action activities necessary for identified incidents
- Proactive incident reduction activities
- Necessity and benefit of root cause analysis performance for identified incidents or proactive reduction activities
- An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and incidents. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and incidents. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and incidents. A focus will be placed on remedial actions to assist rather than punish staff members, with the Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.
 - Sentinel Events - staff members involved in a sentinel event incident will receive support from the Environment of Care and Performance Improvement Committees regarding the staff member's professional and emotional reconciliation of the sentinel event. The Environment of Care and Performance Improvement Committees encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Service Department, Human Resources Department and/or his or her department supervisor.
 - As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to The Joint Commission. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting the safety or quality of care concern to The Joint Commission.



Mountain's Edge Hospital

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN

ORGANIZATIONWIDE

Reference #1502

Page 10 of 12

All approval information is stored in the Online Policy Manager. A hard copy may be found in Administration at any time.

- On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.
- The Patient Safety Program includes implementation of the recommendations set forth by The Joint Commission, or identified alternative recommendations defined by this institution, to achieve compliance with The Joint Commission established National Patient Safety Goals. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified National Patient Safety Goals.
- The Patient Safety Program includes a quarterly survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Environment of Care and Performance Improvement Committees will request a report on at least a quarterly basis consisting of random record review verifying compliance with informing the patient about outcomes of care. The Environment of Care and Performance Improvement Committees will analyze error reporting data submitted through the Performance Improvement Department for evidence of this information.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. The Environment of Care and Performance Improvement Committees will request a report on at least a quarterly basis consisting of random record review verifying compliance with this educational process.
- The Patient Safety Program includes consideration, at least annually, of data obtained from the organizational Information Management Needs Assessment, which includes information regarding barriers to effective communication among caregivers. The Environment of Care and Performance Improvement Committees will also request on at least a quarterly basis, a report identifying the effectiveness of the organization to provide accurate, timely, and complete verbal and written communication among care givers and all other involved in the utilization of data.
- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need

 MOUNTAIN'S EDGE Hospital	Reference #1502
	Page 11 of 12
Mountain's Edge Hospital	
SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN	
ORGANIZATIONWIDE	

All approval information is stored in the Online Policy Manager. A hard copy may be found in Administration at any time.

and method to report medical/health care errors. Education includes the staff member's right to report any safety or quality of care concerns to The Joint Commission. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

- Medical/health care errors and incidents, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.
- Lessons learned from a root cause analysis shall be communicated to staff who provide services or are affected by a patient safety incident. Education shall take place through the Education Department.
- Patient safety reports from the Environment of Care Committee will be submitted to the organizational Performance Improvement Committee, which exists as the oversight committee for the Environment of Care Committee. A monthly data report and recordings of meeting minutes will be forwarded to the Performance Improvement Committee, with all information submitted held under the auspices of the Performance Improvement Committee.
- A written Patient Safety Report shall be forwarded to the Governing Body, at a minimum, once per year. Information in the report shall include:
 - All system or process failures
 - Number and type of sentinel events
 - If patients and families were informed of the adverse events
 - All actions taken to improve safety, both proactively and in response to actual incidents

REFERENCE:

CMS Improves Patient Safety for Medicare and Medicaid by Addressing Never Events, August 4, 2008,
<http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3224&intNumPerPage=10&ch>



Mountain's Edge Hospital

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN

ORGANIZATIONWIDE

Reference #1502

Page 12 of 12

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Section Title: Facilities And Environment	Section: 8
Subject : Safety Management Program	Policy: 8.3

POLICY

The purpose of this plan is to establish, support, and maintain a safety program that is based on monitoring and evaluation of organizational experience, applicable federal and state laws and regulations, and accepted practice within the healthcare industry.

Goal

The safety management plan goal is to provide a physical environment free of hazards and to manage staff activities to reduce the risk of human injuries that could affect employees, patients, visitors, and/or guests. To prepare facility's personnel to be able to demonstrate/conduct the evacuation of a patient.

Objectives

This plan is based on the following objectives:

1. Maintaining and supervising all grounds, buildings, and equipment, including special activity areas used by patients.
2. Ensuring that emergency service areas are clearly identified and easily accessible.
3. Establishing a risk-assessment program that proactively evaluates the impact on patient and public safety of the buildings, grounds, equipment, occupants, and internal physical systems.
4. Providing a safety officer, appointed by the administration, who is qualified by experience or education; responsible for developing, implementing, and monitoring the organization's safety program; and intervening whenever conditions exist that either pose an immediate threat to life or health or pose a threat of damage to equipment or buildings.
5. Reporting and investigating all incidents that involve property damage, occupational illness, and patient, employee, or visitor injury.
6. Requiring organization safety policies and procedures that are distributed, practiced, and enforced.
7. Reviewing the organizational safety policies and procedures as frequently as necessary, but no less than annually.
8. Promoting an ongoing hazard surveillance program, including response to product safety recalls.
9. Using safety-related information in the orientation of new employees and continuing education of employees.
10. Requiring an annual plan and evaluation of the objectives, scope, performance, and effectiveness of the documented safety management plan.

Policy elements

1. Safety management policy statement
2. Each employee is required to comply with safety and health standards and with the policies and procedures that apply to their job responsibilities in an effort to maintain a safe environment. Any violation of policy may result in disciplinary action.
3. Anesthesia personnel should review and be familiar with the facility's written emergency protocol for cardio-pulmonary emergencies and other internal and external disasters.
4. Maintenance and supervision of grounds and equipment

The Quality/Risk Management Committee will develop written policies and procedures to enhance safety within the facility and on the grounds. Monitor equipment and utility preventive maintenance and inspection procedures, and monitor the education and training of users to protect against failure or user error.

Equipment Safety Checklist includes but not limited to:

- Back-up emergency power system (UPS)
- Defibrillator
- Electrocautery or Bovie unit
- Laser
- Magnehelic Gauge
- Meds Refrigerator temperature
- Nurse annunciator system
- Operating or procedure table
- Oxygen / Nitrous gas cylinders, regulators, gauges
- Pulse oximeters
- Suction system or aspiration units
- Surgeon's headlights
- Surgery light or procedure lights in operating room(s)
- Vital signs monitores

An environment tour will be made of the buildings and grounds of the facility to ensure maintenance, supervision, and safe use of these buildings and grounds by patients, staff, and visitors. Patient areas will be assessed a minimum of twice yearly, non-patient areas a minimum of annually. All buildings shall comply with the appropriate provisions of the National Fire Protection Association's Life Safety Code®, 2000. Consideration will be given to parking lots/structures and the security and safety needs of these facilities, recreational areas, and special terrain problems. Plans and policies will be developed and implemented to cover security, safety, and the functional needs of patients, visitors, and employees.

Risk assessment

The safety management program, which proactively evaluates the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety, is carried out by using incident reports, accident investigation, and reports from various agencies, such as insurance companies, state or county health agencies, and fire agencies.

Hazard surveillance

An ongoing hazard surveillance program, including response to product safety recalls, shall be maintained and reported through the Quality/Risk Management Committee.

Examination of safety issues

All safety-related issues shall be examined by the Quality/Risk Management Committee. The Quality/Risk Management Committee shall include representation from those areas deemed appropriate. Nonsupervisory employees will participate in activities of the safety program. All members of the Quality/Risk Management Committee are appointed by the administration/safety officer or designee. The Quality/Risk Management Committee shall evaluate the safety management program compliance by evaluation at least annually.

Incident/injury/illness reporting and investigation

The Quality/Risk Management Committee/risk management committee shall review all reports of accidents or injuries to patients, visitors, and/or personnel. Summary reports of incidents shall include description of the incident, cause, corrective actions taken, and preventive measures taken. Refer to the appropriate policies and procedures. The Quality/Risk Management Committee will establish an incident reporting system for investigating and evaluating all incidents reported and for documenting review of all such reports and actions taken.

Safety officer/designee

The safety officer and the Quality/Risk Management Committee are appointed by the administration. Administration has delegated to the Quality/Risk Management Committee the authority to take action when hazardous conditions or potential hazardous conditions exist that could result in personal injury to individuals or damage to equipment or buildings. This delegated authority has been approved by the administration and the board of directors of the facility.

New employee orientation and continuing education

1. An employee's orientation program shall address general safety processes, area-specific safety, and specific job-related hazards.
2. The Quality/Risk Management Committee will provide safety-related information through orientation of new employees
3. continuing education on employee and patient health issues
4. use of all means of communication to support the program requirements or to communicate safety issues
5. recommendation purchases of safety equipment and suggestions for any necessary physical changes to improve safety conditions

The Quality/Risk Management Committee shall coordinate the facility educational activities to effect improvements in the safety of patients, visitors, and staff. Educational programs shall include general safety procedures, department-specific safety procedures, and specific job-related hazards. Educational programs shall be based on industry standards and literature review and shall be continually adapted to reflect organizational experience and evaluation of effectiveness of training programs.

Performance improvement

The Quality/Risk Management Committee shall meet quarterly/when necessary and record the activities. A review of the safety program's performance shall be conducted at least annually. Summaries of all findings shall be forwarded to administration, the quality improvement (QI) department, and the appropriate oversight committee(s).

Performance indicators

The following indicators shall be utilized in evaluating the performance of the safety management program:

1. Environmental health and safety
2. Life safety management
3. Emergency preparedness
4. Security
5. Hazardous materials and waste
6. Infection control
7. Equipment management
8. Utilities management

Inspection, preventive maintenance, and testing of equipment

Monitor equipment and utilities for preventive maintenance and inspection procedures and monitor education and training of users to protect against failure or user error.

Safety policies and procedures

The Quality/Risk Management Committee or responsible department will develop written policies and procedures to enhance safety within the facility. All safety policies will be reviewed annually in accordance with facility policy. Any revisions, updates, or changes shall be submitted to the appropriate authority for approval. The ultimate responsibility for development and maintenance of current safety policies shall lie with the safety officer.

Annual evaluation

The safety management program will be evaluated at least annually for its effectiveness. Evaluation shall include all areas of safety management.

Responsibilities

1. Executive leadership
2. Toward fulfillment of the general and specific safety goals of the safety management plan, executive leadership shall
3. Appoint a safety officer(s) (of the Quality/Risk Management Committee) who is qualified to oversee the safety management program
4. The facility must have a written list of all equipment, materials and supplies necessary to properly carry out job assignments.

Safety officer

Toward fulfillment of the general and specific safety goals of the safety management plan, the safety officer shall provide oversight for the health and safety program at the facility

Management

Because good safety performance is an essential factor in effective cost and quality control, safety cannot be subordinated to other management interests. It must be considered as part of every operation and every function. Because they are responsible for the actions of persons reporting to them, each supervisor has the obligation to communicate safety policies and enforce safety procedures. To fulfill this responsibility, they shall enforce facility safety rules and regulations, documenting all violations. Supervise and evaluate employee performance with regard to safety on the job. Provide personal support for safety activities and safety procedures. Take prompt corrective action when unsafe acts or conditions are observed. Ensure that a safe work environment is provided for employees. Ensure that safety has been considered prior to the commencement of each task or function, not only for their own personnel, but for others who may be exposed or affected, including patients. When necessary, develop techniques and procedures relative to specific work operations or tasks, ensuring proper consideration of safety. Instruct each employee, during the orientation period and annually (or according to your accreditor or other regulating body), in the hazards associated with assigned duties and how to avoid injuries.

1. Ensure, through instruction and surveillance that each employee is aware that he or she is expected to work safely and that willful violations of safety rules will be cause for disciplinary actions, up to and including termination.
2. Instill safety awareness in each employee by personal example, regular personal contacts, and group meetings.
3. Motivate employee interest and participation in the safety program by setting an example and soliciting suggestions.
 - a. cooperate fully with safety officer/the Quality/Risk Management Committee in the promotion of safety activities.
 - b. Seek assistance from the safety officer relative to safe practices and procedures.
 - c. Ensure that employees receive all required safety training and education.
 - d. Assist in conducting training as needed.
 - e. Know and instruct employees in emergency actions, including evacuation procedures from all work areas.
 - f. Have new or relocated equipment and instrumentation checked and approved by facility services before it is placed in operation.
 - g. Ensure that adequate safety equipment and protective devices are provided for each job in each work area(s), as required, and that such equipment is properly used and maintained by the employees.
 - h. ensure that all injuries are reported and, if necessary, treated immediately.
 - i. investigate all accidents and incidents in their area to determine whether injuries resulted, and make the required reports.
 - j. participate actively when called on to serve on the Quality/Risk Management Committee. Further, appoint an alternate from the department who can attend committee meetings and represent the department in the absence of the department supervisor.

All Employees

For the safety program to be successful, each employee must know and utilize the contents of this policy to the best of his or her ability and with respect to each individual's job requirements. The absence of a safety standard on a specific job or task does not relieve employees of the safety responsibility concerning that job. If employees find that specific safety information is not available in this policy, they should contact their respective management and ask for the required information. Employees have been hired to perform their job safely and are expected to work as safely as possible and to support the safety management program.

They shall:

1. learn the safe and correct way to perform their assigned duties and shall ask their supervisor anything about which they are in doubt
2. perform their jobs in a safe, responsible manner using required safety devices and personal protective equipment provided by the health facility, following established procedures, and wearing proper, clean clothing suitable for the job they were hired to perform take no chances or short cuts in the performance of any task or procedure
3. report any accident, personal injury, or patient complaint regarding the health or safety practices, no matter how slight, to their supervisor
4. immediately report any hazard observed and suggest to the supervisor better and safer ways to perform tasks
5. always be fit for their assigned duties by practicing good health habits and personal cleanliness
6. practice good housekeeping at all times; keep equipment, tools, materials, instruments, and work areas clean and orderly
7. attend all required safety-related training
8. know what actions to take in case of fire or other emergency situation in their work area(s)
9. comply with no-smoking requirements in all patient care and hazardous areas

Spring Valley Surgery Center LLC

2018 Sentinel event reporting

3835 S. Jones Blvd. Las Vegas NV 89103 License #: 3421

2705 W. Horizon Ridge Pkwy Henderson NV 89052 License #: 5491

7175 N. Durango Drive Las Vegas NV 89149 License #: 7592

1900 N. Nellis Blvd Las Vegas NV 89115 License #: 7891

1050 E. Sahara Ave Las Vegas NV 89104 License #: 8688

8828 Mohawk Street Las Vegas NV 89139 License #: 8787

Safety committee:

The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the Federal, State, Local and OSHA guidelines. The “Safety Plan” includes identification, evaluation and prevention of workplace hazards relating to the elements and specific criteria. The safety management of the Facility is composed of several elements regarding the safety features necessary for the protection and security of its patients and healthcare workers.

These elements are composed of two parts; one “Life Safety Enterprise Safety Plan” which is wide in scope, organizational and effectiveness, and the “Environmental Safety Management” which oversees the working environment elements of the Facility. These areas overlap each other but also provide individual elements which manage the overall security and safety of the Facility. A report from the Safety Committee is provided quarterly to the Medical Executive Committee (MEC) and onto the Governing Board. The Safety Committee meets and discusses how to improve and/or maintain patient and employee well-being and safety, items discussed range from falls to how to properly lift boxes, and the execution of a disaster drills, etcetera. If any incidents have occurred they will be discussed in detail, and prevention and safety will be implemented.

SUNSET RIDGE SURGERY CENTER, L.L.C.

MANUAL: Policy & Procedure Effective Date: 7/21/2014
SECTION: Safety Management Plan Reviewed Date: 7/1/2018
POLICY: 14.20 Patient Safety Program Revised Date:

PURPOSE: To provide quality, safe patient care, thus preventing errors and adverse events during the pre, peri, & post-operative phases of care.

PROCEDURE:

- A. The Administrator, Clinical Coordinator, Medical Director, and governing board will emphasize teamwork in building a culture of safety in this setting.
 1. The Center will take a proactive approach to identify and address activities for potential risk before errors occur.
 2. Effective communication will begin with the leaders and continue to other staff via memos, meetings, open discussions and networking.
 3. Educational tools will be given to the staff. In-service programs will be offered. Articles on safety related items will be distributed and maintained.
 4. Leadership will encourage and support cooperative openness and professionalism between the surgeon and nurses. When question arises, the team should stop and review the patient's chart for accurate information. No one should make assumptions.
 5. Leadership will be responsible to create a non-punitive environment that encourages all reporting
 6. The center will report *any incidents/ events resulting in a death or serious physical/psychological injury* or risk there of or near misses.
 7. The Administrator (or designee), Medical Director and or surgeon will be responsible to tell a patient if he or she has been harmed by the care received. There will always be two (2) people present when the patient is notified
 8. All incident reports will be reviewed, analyzed, and trended by the Safety/Risk Management and Continuous Performance Improvement Committee.
 9. The Medical Executive Committee will review the Center's Safety/Risk Management plan annually, & results of incidents as they occur or bi-annually.
- B. Staff members will participate in education and training to improve competence.
 1. Defining potential adverse events:
 - i. *An unexpected occurrence during a health care encounter involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition.*
 - ii. *Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.*

- iii. *Events such as breaches in medical care, administrative procedures or other breaches resulting in a negative impact on a patient, even if death or loss of limb or function does not occur.*
 - 2. Immediate verbal and written reporting of any occurrence.
 - 3. Committee involvement to participate in analysis and possible change in processes to provide a safe patient environment.
- C. Establish, maintain and review policies to comply with nationally recognized standards of care; i.e., AORN WHO CDC, AAHC, OSHA
 - 1. Policies include, but not limited to:
 - i. Ensure competency of the staff
 - 1. Registered nurses will maintain ACLS, BLS, & where appropriate, PALS certification.
 - 2. Non-professional clinical staff will maintain BLS certification
 - 3. Annually update & demonstrate competencies.
 - 4. Emergency drills are practiced annually
 - ii. Safety practices are in place to protect the patient during times of dependence.
 - 1. An identification bracelet is provided and visually checked before administration of medications or start of procedure
 - 2. The name of the patient's primary physician is documented on the medical record for reference in case of an emergency situation
 - 3. Safety devices are used; i.e., non-skid slippers, side rails, safety straps, locks on stretchers and chairs.
 - 4. Providers protect the patient from pressure and injury through knowledge of proper body mechanics, positioning, and padding of pressure points
 - 5. Patient asked for verbal identification of the type and site of surgery while in the pre-operative area. The site will be marked pre-operatively by the physician/surgeon while the patient is awake & oriented in the pre-operative area. An intraoperative "TIME OUT" is performed after draping, & prior to incision in presence of the surgeon, anesthesia provides, scrub and circulator.
 - 6. Sharp objects and unprotected needles are not placed in contact with or near the patient at any time.
 - 7. Sponges, needles, and instruments are accounted for before closing body cavity
 - 8. Radiopaque sponges are used intra-operatively
 - 9. The patient is appropriately protected from radiation, electrical and laser injuries.
 - 10. Suction is immediately available for unconscious patients.
 - 11. Patients with artificial airways in place are constantly attended.
 - 12. Two licensed providers are present at all times when a post-op patient is in the building.
 - 13. Two providers are available to help with the initial ambulation of patients who are at risk for falling.

14. Discharge of the patient who has received anesthesia or sedation is allowed only when a patient is accompanied by a responsible adult.
- iii. Medications are stored and administered safely
 1. Adequate stock of medications is maintained
 2. Security of medication from tampering, theft, and unauthorized use is ensured
 3. Expiration dates, color & clarity are checked before use.
 4. Outdated medications are removed from the storage area of medications in use
 5. Medication is stored in the appropriately controlled environment.
 6. Emergency drugs are checked for expiration dates at least monthly and are replaced immediately if used or outdated.
 7. Allergies are identified and consistently documented in a prominent and consistent location on all patient records.
 8. All patients with known allergies are identified with a red arm-band. Admitting nurse verifies allergies with the patient & notes allergy and known reaction on the red band.
 9. Nurses follow safe standards of practice identifying the drug, dose, route, time, patient's name and all allergies before administering medications.
 10. All patients are observed for untoward or allergic effects of medications administered.
 - iv. Ensure staff effectiveness
 1. The patient is appropriately attended.
 2. Heavily sedated or anesthetized patients and children are attended at all times.
 3. Patients have a method for summoning assistance within reach at all times
 4. Interventions are employed to prevent patient falls
 5. An anesthesia provider is immediately available until patients have been evaluated and discharged.
 - v. Appropriate and safe equipment is available
 1. All technical and electronic equipment is tested for safety and checked/and or calibrated by a Biomed Engineer bi-annually & records maintained in the administrator's office.
 2. Unsafe or questionable equipment is taken out of service, labeled and service call initiated.
 3. Directions are readily available for all equipment.
 4. Emergency equipment is checked daily for function and staff familiarity.
 5. Portable emergency equipment allows for safe transport to the hospital if necessary.
 6. Emergency generator is checked weekly, monthly and inspected at least twice a year by contracted maintenance personnel
 7. An internal and external communication system is available throughout the facility
 - vi. Principles of asepsis are maintained

1. All providers are knowledgeable of and practice proper techniques to prevent the spread of disease and germs
 2. Strict aseptic technique is followed in the OR and other nursing units for noninvasive or minimally invasive procedures.
 3. All personnel are truthful and ethical about any break in sterile technique
 4. Sterility of supplies is ascertained through ongoing monitoring of autoclave function, checking of expiration dates, rotating of stock, and monitoring of individual techniques of packaging for sterilization
 5. Providers with highly contagious disease will not be involved in the care of surgical patients.
- vii. Decisions about the healthcare are made thoughtfully and with regard to the individual
1. A physician knowledgeable of the patient directs the patient's care, including discharge.
 2. All pertinent and preoperative tests results are available and assessed before administration of anesthesia or the onset of the procedure.
- viii. Management recognizes the need to provide support to staff members involved in a sentinel event. Support systems will focus on the process rather than blaming individuals involved
- ix. Fire Safety- See 12.5- 12.9 in Section 12- Life Safety Management Plan

Ear Nose and Throat Surgery Center: QUALITY AND PATIENT SAFETY PLAN

DATE: 01/1/2019
VERSION: 01



This plan was created and revised by the Ear Nose and Throat Surgery Center Quality Improvement and Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

Quality Improvement and Patient Safety Committee/Program
Ear Nose and Throat Surgery Center:
8840 W. Sunset Rd. Suite B, Las Vegas, NV 89148
702-209-3377

Contents

Commitment to Patient Safety.....	3
Mission, Vision, and Values	3
Scope and Purpose.....	3
Roles and Responsibilities.....	4
Roles and Responsibilities	5
Objectives and Goals of the Quality and Patient Safety Plan	7
Components and Methods	8
Root Cause Analysis.....	<u>9</u>
Model for Improvement.....	10
Data Collection and Reporting.....	11
Assessment of the Quality and Patient Safety Plan	<u>131312</u>
Patient Safety Checklists and Patient Safety Policies	<u>131312</u>
Approval of Patient Safety Plan.....	<u>151514</u>
Reference.....	<u>161614</u>
Appendix A: Terms and Definitions	<u>161615</u>
Appendix B: Patient Safety Goals	<u>191918</u>
Appendix C: Fishbone Diagram.....	<u>202019</u>
Appendix D-1: PDSA Worksheet.....	<u>212120</u>
Appendix D-2: PDSA Monthly / Quarterly Progress Report	<u>232322</u>
Appendix E: Checklist Example: Injuries from Falls and Immobility.....	<u>242423</u>
Appendix F: Policy Example.....	<u>252524</u>

Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, Ear Nose and Throat Surgery Center LLC Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

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

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

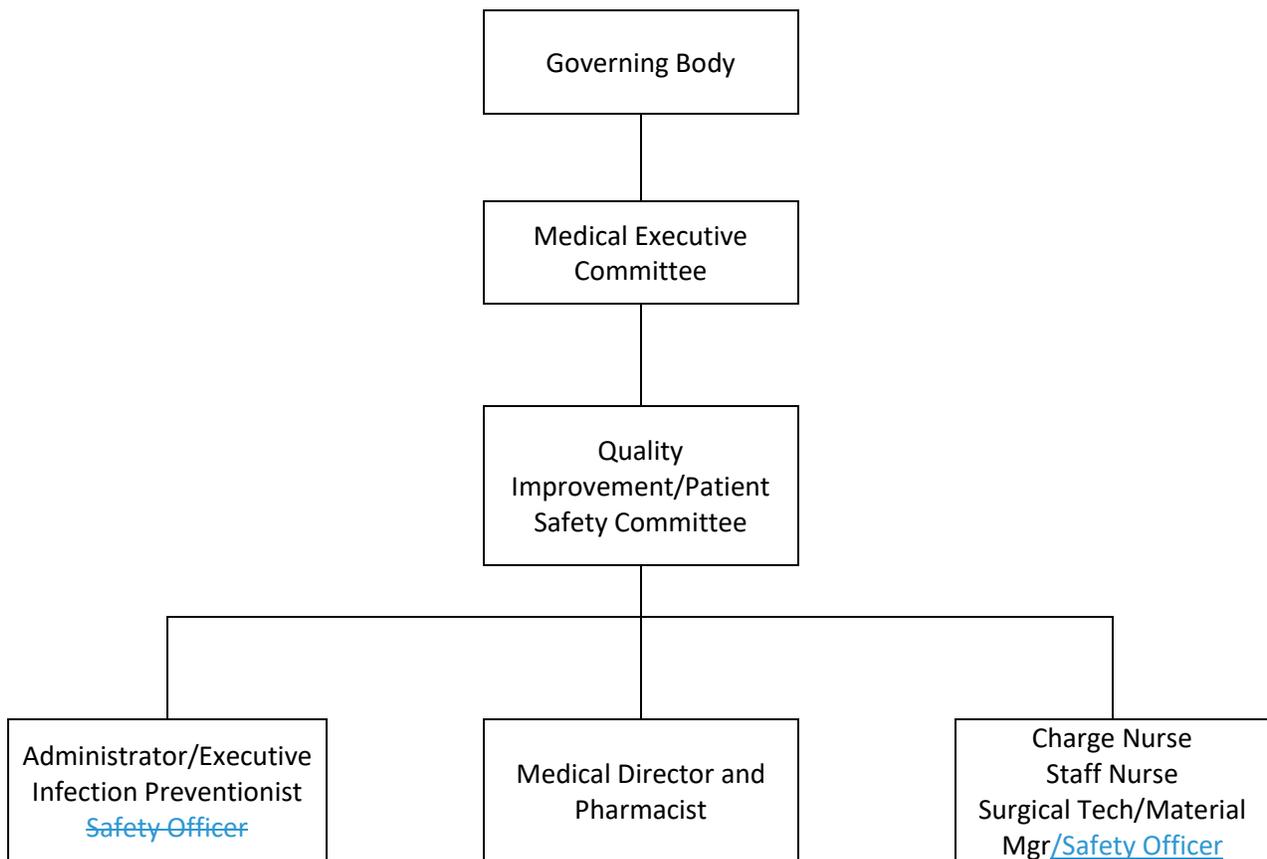
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

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

Roles and Responsibilities

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

The Patient Safety Committee Organization



Roles and Responsibilities

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

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

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

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Monitors and reports to the Quality Improvement/Patient Safety Committee safety statistics.

Infection Control Officer Responsibilities (based on NRS 439.873)

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

RCA team leader/Facilitator Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

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

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

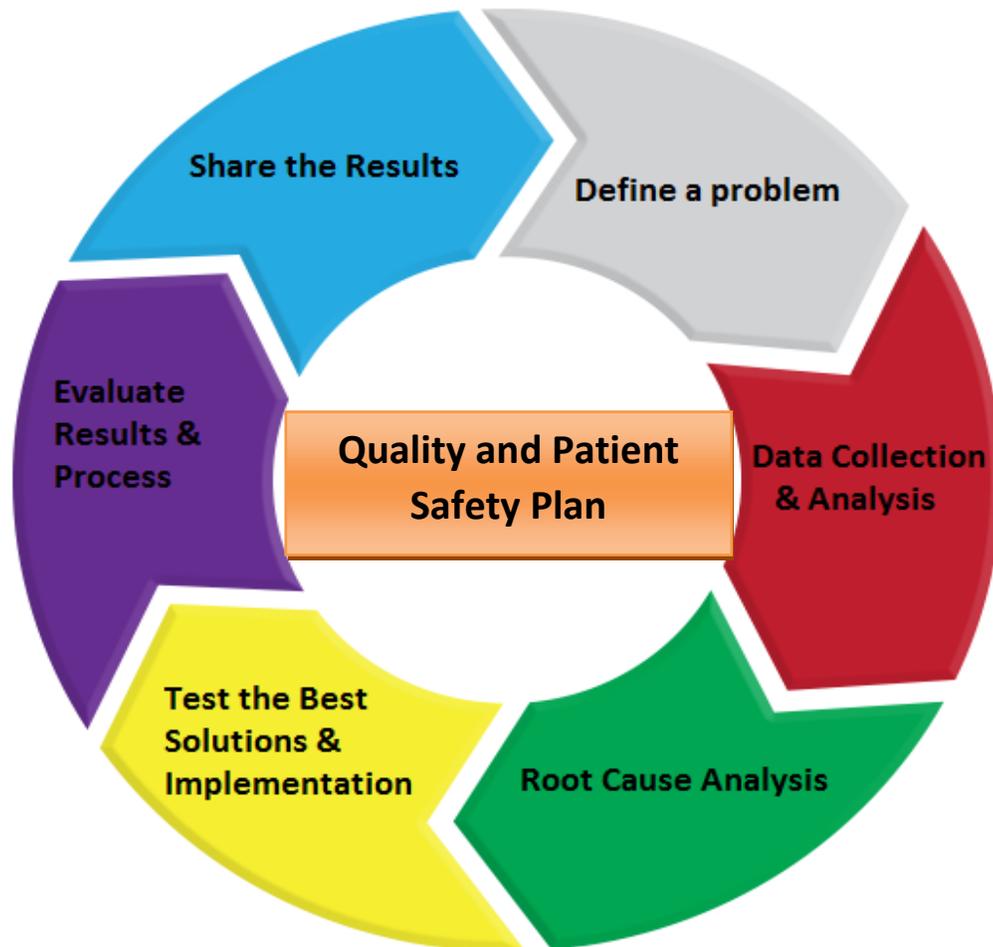
Objective	Plan	Planned Completion Date	Responsible Party
See Objectives in Quality Improvement Plan 2019			

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Components and Methods

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

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



Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Ear Nose and Throat Surgery Center to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

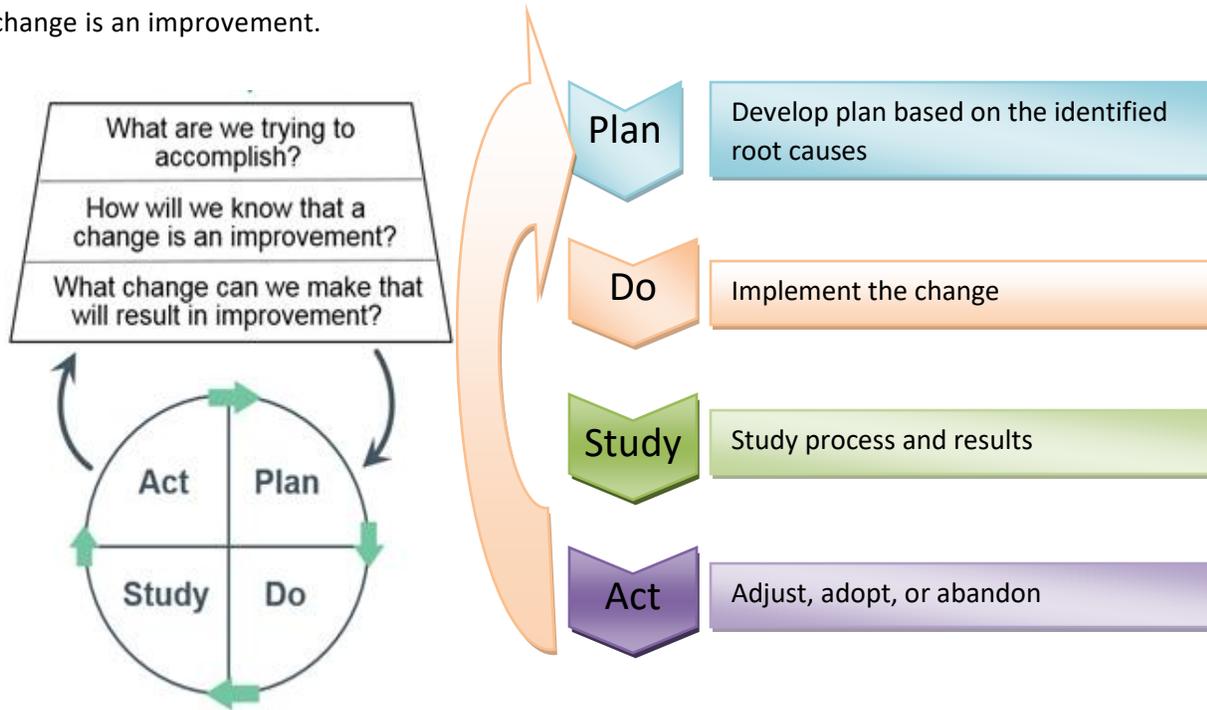
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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



The cycle is defined as follows:

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

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

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. (Facility name) is using (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

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

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



| Ear, Nose and Throat Surgery Center Facility Name LLC: _____

P

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

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

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

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

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF),

Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

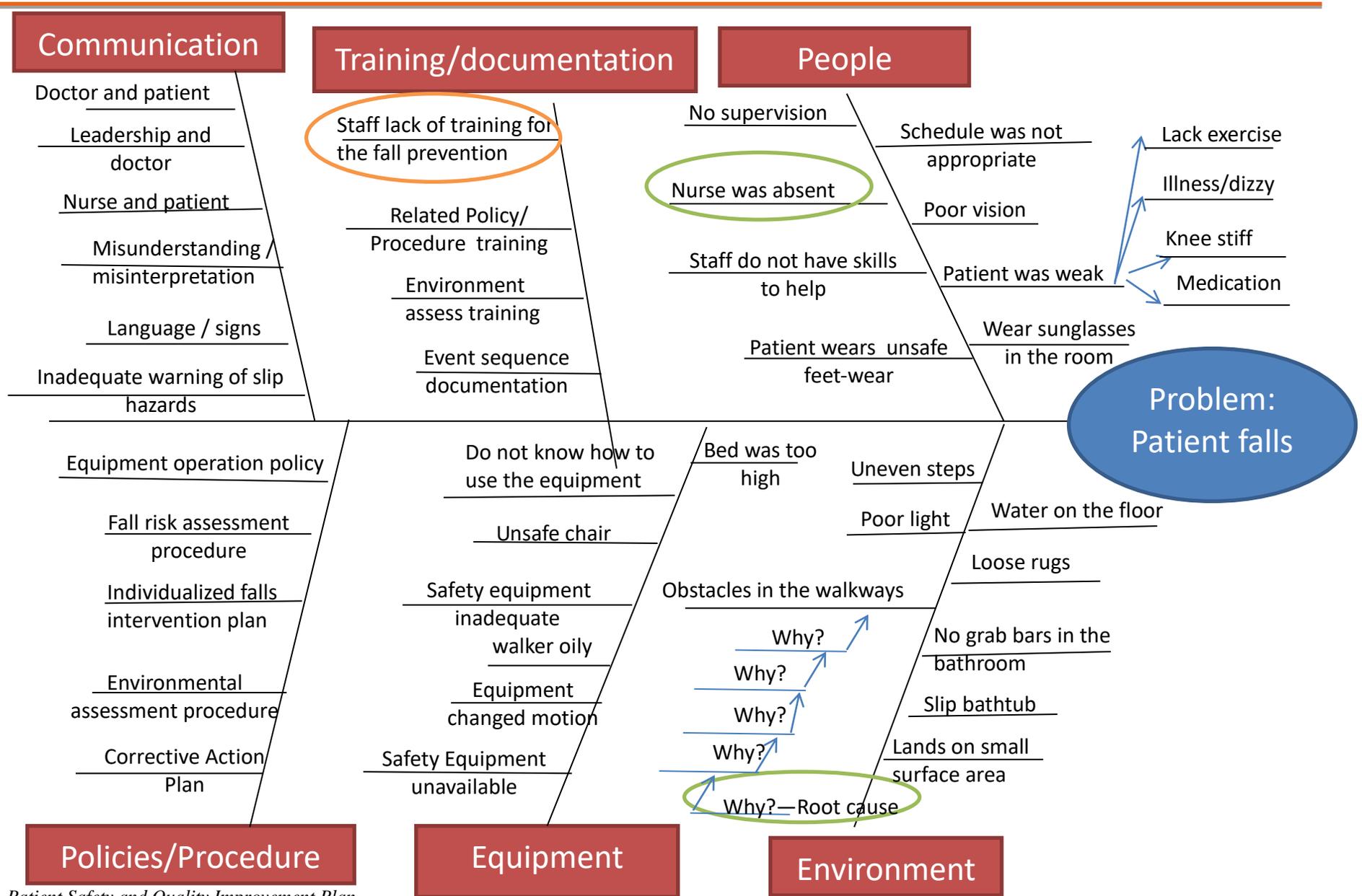
Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.	Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS. Increase number of events reported by 10%. Create process for communicating outcome of reported events.	
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Complete 2014 Leapfrog Safety Survey.	Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee. Establish & implement a plan to improve performance of each leap.	
		Develop method to track & report departmental progress and compliance of RCA action plans.		
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.		Establish Patient Safety Council.	
		Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols.		

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Patient Safety and Quality Improvement Plan

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	
<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

	HOSPITAL POLICY AND INFORMATION MANUAL		[Reference: Hospital Policy]
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>	<p>Date Issued: 07/01 08/14 Date Last Revised: 08/17 Next Review Date: Approved By:</p>	<p>Policy Committee</p>	

es. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQUIP5 - 1.5.1 and 1.5.2 Infection Control
- EQUIP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

	HOSPITAL POLICY AND INFORMATION MANUAL	
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

Patient Safety Committee and Reporting

Patient Safety is the responsibility of all employees and Medical Staff members. The Patient Safety Program will be multi-faceted and that responsibility will be shared among several individuals, groups, and teams. Each performance improvement team is multidisciplinary in nature with representatives from the hospital and medical staff. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement teams are sent to the Quality Council and reported to the Medical Executive Committee and the Governing Board.

In compliance with State of Nevada Regulations, the Patient Safety Committee will be comprised of:

- (1) The patient safety officer of the medical facility.
- (2) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.
- (3) One member of the executive or governing body of the medical facility.

The Patient Safety Committee is also multidisciplinary with representation from the following areas: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management, and the Hospital's Infection Control Preventionist.

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:
 - a. Risk and Safety Management
 - b. External Data Reports
 - c. Sentinel Event Alerts from the Joint Commission
 - d. Healthcare Reports
 - e. Regulatory Reports
 - f. Patient/Family Members
2. Continually improve processes of care delivery based on data analysis.
3. Develop policies and procedures that result from process improvement activities.
4. Develop and approve Patient Safety Education for the medical and hospital staff.
5. Conduct an annual risk assessment of patient safety issues/strategies from internal and external reports.

The Hospitals believe in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator/CEO.

The activities of the Patient Safety Program and an annual review of the Patient Safety Plan, appropriate policies, forms, checklists and best practices will be reported to the Patient Safety Committee, the Medical Executive Committee, and the Governing Board as outlined in the Performance Improvement Plan and the LifeCare Reporting Calendar. Communication within the hospital and medical staff is the key to a successful patient safety program and will be encouraged.

Education and training is an important and effective tool in assuring that the Patient Safety Program is clearly understood, particularly error identification and reporting and the basic approaches to Patient Safety. Education and training on patient safety is included in new employee general and department orientation and reviewed annually. Additionally, education will be provided to patients and their families about their role in helping to facilitate the safe delivery of care.

SHSC	SIENA HEIGHTS SURGERY CENTER		
	<small>ORIGINAL DATE</small> October 2014	<small>REVISED DATE</small>	<small>PAGE NUMBER</small> 1 of 2
	<small>SUBJECT</small> SAFETY PROGRAM		<small>ADMINISTRATOR</small> Kim Lewis, RN
<small>POLICY NUMBER</small> 9-20			<small>MEDICAL DIRECTOR</small> Dr. Mike Fishell

POLICY:

The SHSC maintains a safety program to address the centers environment of care, safety of patients, staff, and others. The safety program is directly linked to the Quality Assurance Performance Improvement Program.

PROCEDURE:

- A. The safety program processes for the management of identified hazards, potential threats, near misses, and other safety concerns like
 - 1. Adverse Incidents
 - 2. Incidents/Injuries
 - 3. Medication Errors
 - 4. Recalls
 - 5. Fall Prevention

- B. Referenced items have their own individualized policies in the policy and procedure manual.

- C. The safety program is supervised by the Quality Assurance Performance Improvement Committee.

- D. Quarterly staff in-servicing is mandatory at the center. Quarterly in-services provide education and training on safety issues such as:
 - 1. Fire Drills and/or Fire Prevention
 - 2. Universal Precautions
 - 3. Sharps Prevention

The center also provides code drills such as:

- 1. Malignant Hyperthermia
- 2. CPR

- E. At time of employment personnel is quizzed and provided competency (s).

- F. Unique patient identifiers are consistently used throughout care.

SHSC	SIENA HEIGHTS SURGERY CENTER	
	ORIGINAL DATE October 2014	REVISED DATE
	PAGE NUMBER 2 of 2	
POLICY NUMBER 9-20	SUBJECT SAFETY PROGRAM	
	ADMINISTRATOR Kim Lewis, RN	MEDICAL DIRECTOR Dr. Mike Fishell

- G. Center has policies for anesthesia support, and post-procedural care.
- H. Center has a written emergency and disaster preparedness plan and documentation of requesting to participate on a community level.
- I. Environmental hazards associated with safety are identified and safe practices are established.
- J. Measures are implemented to prevent skin and tissue from injury from chemicals, cleaning solutions, and other hazardous exposure.
- K. Patients are educated about prescribed medical devices and associated protocols and guidelines.
- L. Reprocessing of single use devices must comply with FDA guidelines.
- M. Products including medications and solutions that carry an expiration date are monitored. The center has policies for disposal of expired medications and supplies in accordance with local, state, and federal guidelines.
- N. The center will designate the nurse manager or surgeon if applicable to provide appropriate education to intended operators of newly acquired devices or products to be used in the care of patients. At SIENA HEIGHTS SURGERY CENTER the Medical Director is designated the Safety Program Officer.

Section 6 Patient Safety	The LV Surgery Center	
Policy Name: PATIENT SAFETY PROGRAM	Page 1 of 7	
Approved: JAN 28 2016	Revised:	

POLICY:

The LV Surgery Center will institute and administer a comprehensive and continuous Patient Safety Program for all patients to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition of risks to patient safety and medical/health care errors
- Actions to reduce these risks
- Internal reporting of incidents and potential incidents and actions taken
- Focus on processes and systems rather than individual blame

PURPOSE:

The Patient Safety Program provides a systematic, coordinated and continuous approach to maintenance and improvement of patient safety by using established mechanisms to support responses to actual occurrences, have an ongoing proactive plan to reduce medical/health errors, and integrate patient safety as a high priority in all relevant organizational processes and services.

RESPONSIBILITY:

As with patient care, it is a coordinated and collaborative effort of the entire organization to maintain and improve patient safety.

The Governing Body approves the data-driven Patient Safety Program and ensures the program reflects the complexity of the facility's organization and services, including those services furnished under contract or arrangement and focuses on the prevention and reduction of medical/health errors and adverse effects.

The Clinical Director is responsible for the management of the Patient Safety Program by:

- Coordinating all patient safety activities
- Facilitating assessment and appropriate responses to reportable events
- Monitoring Root Cause Analysis and resulting action plans

Section 6 Patient Safety	The LV Surgery Center	
Policy Name: PATIENT SAFETY PROGRAM		Page 2 of 7

- Serving as a liaison among the departments to assure facility wide integration of the Patient Safety Program.

Each individual employee within the organization acts as a patient advocate for safety and is responsible to report patient safety occurrences and potential occurrences to the QAPI Coordinator and the Clinical Director, who will aggregate the occurrence information and report to the Governing Body.

PROGRAM:

The scope of the Patient Safety Program includes an ongoing assessment to prevent error occurrence, maintain and improve patient safety.

Patient Safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed to prioritize organizational patient safety efforts.

Types Of Patient Safety Or Medical/Health Care Errors:

- No Harm Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
- Mild-Moderate Adverse Outcome Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one of the following (even if the outcome was not death or major permanent loss of function):
 - Suicide of a patient.
 - The sexual assault of a patient during treatment or while the patient was on the premises of the facility.
 - A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
 - Medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient.
 - A surgical procedure on the wrong patient or on the wrong body part of a patient.
 - A foreign object accidentally left in a patient during a procedure.
 - A patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
 - Near Miss – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

What To Do When A Patient Safety Error Occurs

Upon identification of a medical/health care error, the patient care provider will immediately:

- Perform necessary healthcare interventions to protect and support the patient's clinical condition.
- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of contaminated IV fluids from supply should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.

Section 6 Patient Safety	The LV Surgery Center	
Policy Name: PATIENT SAFETY PROGRAM		Page 4 of 7

- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, piggyback fluid for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
- Report the medical/health care error to the staff member's immediate supervisor.
- Submit the incident occurrence report to the QAPI Committee per organizational policy.

Internal Reporting Of The Error/Event

Staff response to medical/health care errors is dependent upon the type of error identified:

- **No Harm Errors** – (including “no harm medication errors), staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident occurrence report form, submit the form to the QAPI Committee and notify their immediate supervisor.
- **Mild-Moderate Adverse Outcome Errors** (including medication errors), staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts in the medical record and on an incident occurrence report, submitting the report to the QAPI Committee per policy.
- **Adverse Drug Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts appropriately in the medical record and on an incident occurrence report, submitting the report to QAPI Committee per organizational policy.
- **Transfusion Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary orders. Staff will then follow the organization policy and procedure for this event.

Section 6 Patient Safety	The LV Surgery Center	
Policy Name: PATIENT SAFETY PROGRAM		Page 5 of 7

- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify their supervisor and document the findings on an incident occurrence report which is then submitted to QAPI Committee
- **Sentinel Event** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure, which includes a root cause analysis and action plan.
- **Near Miss** – staff will report the near miss event to their immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to QAPI Committee.
- It is the intent of this facility to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to, their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the individual staff member’s supervisor determining the appropriate course of action to prevent error recurrence.

Root Cause Analysis

- All sentinel events and near miss occurrences will have a root cause analysis conducted to examine the cause and effect of the event through an impartial process
- A Root Cause Analysis is an interdisciplinary review process for identifying the basic or contributing causal factors that underlie a variation in performance associated with an adverse event or reportable patient safety event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.
- The QAPI Committee is responsible for conducting the root cause analysis. It will be completed within 45 days of becoming aware of one of the reportable events. They will encourage the staff members’ involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution.

Section 6 Patient Safety	The LV Surgery Center	
Policy Name: PATIENT SAFETY PROGRAM		Page 6 of 7

A written Root Cause Analysis and “Action Plan” will be created which includes specific measures to correctly identify problems or areas of concern, identify strategies for implementing system improvements; and also includes outcome measures to indicate the effectiveness of system improvements in reducing, controlling or eliminating identified problem areas. The action plan must specifically address responsibility for implementation and oversight, time frames for implementation, and the strategy for measuring the effectiveness of the actions.

- The Joint Commission recommended “A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event” format may be used. See attached.
- Results of the entire Root Cause Analysis will be presented to the Governing Body for evaluation.

Communication of Action Plans and Root Cause Analysis

- Action Plans related to a Root Cause Analysis will be shared with the entire staff upon Completion by the QAPI Committee. Possible recommendations to update or change policy and procedures may be presented to the staff, management and Governing Body to improve patient safety.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. There will be a random record review verifying compliance with this educational process.
- Root Cause Analysis and Action Plans will be made available to the state health department representatives during onsite reviews.

Reporting Obligations

- Medical/Health care errors and occurrences, including sentinel events, will be reported internally and externally, through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

Patient Safety Program Staff Education/Training

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

- Medical errors results from multiple factors. Flawed systems or processes can combine with active failures by caregivers in the clinical setting to produce accidents and errors. Some contributing factors are:
 - Inadequate communication among team members
 - Incomplete review of patient health records and diagnostic studies
 - Traditional hierarchical and autocratic cultures
 - Patient – related decisions made only by physicians
 - Unclear instructions
 - Confusing packaging of medications and supplies
 - Time pressures and constraints, Multi-tasking
 - Failure to include the patient and family members in assessment and decision-making

- Staff will be trained about error reduction, which requires the commitment of all members of the health care team. Besides correcting the identified factors above, the following individual and facility changes will be focused on:
 - Reduce reliance on memory by using checklists and protocols.
 - Standardize processes as much as possible for procedures and other activities.
 - Focus on the safety aspects of products during the selection and evaluation process.
 - Promote safety related clinical competency.
 - Educate employees about the potential for errors and how to avoid them.
 - Creating a “Culture of Safety” whereby there is a change of environment from blaming individuals for errors to one in which errors are treated as opportunities to improve systems. This is accomplished by:
 - establishing a sense of trust among team members;
 - dissemination and verifying receipt of information to all levels of staff and management;
 - developing and supporting a proactive approach rather than a reactive approach;
 - making a sincere commitment to affirming safety as the first priority.

- Quarterly Patient Safety Program meetings will be incorporated into the QAPI Program and conducted to review any incident occurrence reports and review any new patient safety recommendations or alerts.

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
What happened?	Sentinel Event	What are the details of the event? (Brief Description)				
		When did the event occur? (Date, day of week, time)				
		What area/service was impacted?				
Why did it happen?	The process or activity in which the event occurred.	What were the steps in the process, as designed? (A flow diagram may be helpful here)				
What were the proximate factors? (typically "special cause" variation)		What steps were involved in (contributed to) the event?				
	Human factors	What human factors were relevant to the outcome?				
	Equipment factors	How did the equipment performance affect the outcome?				
	Controllable environmental factors	What factors directly affected the outcome?				
	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influences this outcome?				
		What other areas of services are impacted?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

The following template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for “root cause” and risk reduction.

As an aid to avoiding “loose ends” the three columns on the right are provided to be checked off for later reference.

- **“Root Cause?”** - should be answered “yes” or “no” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that is relevant to the event is not a root cause, be sure that is addressed later in the analysis with a “why?” question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- **“Ask Why?”** - should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn’t occur when it should have (in other words, to drill down further). Each item checked in this column should be addressed in the analysis with a “Why?” question. If it is expected that any significant finding that are not identified as root causes themselves have “roots.”
- **“Take Action?”** - should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write down the number of the associated Action item on page 3 in the “Take Action?” column for each of the findings that requires action.

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
<p>What happened?</p> <p>Why did that happen? What systems and processes underlie those proximate factors?</p> <p>(common cause variation here may lead to special cause variation in dependent processes)</p>	<p>Human Resources Issues.</p>	<p>To what degree is staff properly qualified and currently competent for their responsibilities?</p>				
		<p>How did actual staffing compare with ideal levels?</p>				
		<p>What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?</p>				
		<p>To what degree is staff performance in the operating process (es) addressed?</p>				
		<p>How can orientation and in-service training be improved?</p>				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
	Information management issues.	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?				
		To what degree is communication among participants adequate?				
	Environmental management issues.	To what degree was the physical environment appropriate for the processes being carried out?				
		What systems are in place to identify environmental risks?				
		What emergency and failure-mode responses have been planned and tested?				
	Leadership issues: -corporate culture	To what degree is the culture conducive to risk identification and reduction?				
	-encouragement communication	What are the barriers to communication of potential risk factors?				
	- clear communication of priorities	To what degree is the prevention of adverse outcome communicated as a high priority?				
	- uncontrollable factors	What can be done to protect against the effects of these uncontrollable factors?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Action Plan	Risk Reduction Strategies	Measures of Effectiveness
<p>For each of the findings identified in the analysis as reading an action, indicate the planned action expected, implementation data and associated measure of effectiveness OR</p> <p>-If after consideration of such a finding a description is made not to implement as associated risk reduction strategy, indicate the rationale for not taking action at this time.</p> <p>-Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.</p> <p>-Consider whether pilot testing of a planned improvement should be conducted.</p> <p>-Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.</p>	ACTION ITEM #1	
	ACTION ITEM #2	
	ACTION ITEM #3	
	ACTION ITEM #4	
	ACTION ITEM #5	
	ACTION ITEM #6	
	ACTION ITEM #7	
	ACTION ITEM #8	
Cite any books or journal articles that were considered in developing this analysis and action plans:		

Facility Name: Nevada Surgical Suites - 8322
Facility Name: Nevada Surgical Suites - 7661

2019 QUALITY AND PATIENT SAFETY PLAN

DATE: 01-23-2019
VERSION: 1.2



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

**Patient Safety Committee/Program
Nevada Surgical Suites**

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Contents

Commitment to Patient Safety3
 Mission, Vision, and Values3
 Scope and Purpose.....3
 Roles and Responsibilities4
 Roles and Responsibilities4
 Objectives and Goals of the Quality and Patient Safety Plan8
 Components and Methods8
 Root Cause Analysis.....9
 Model for Improvement10
 Data Collection and Reporting.....11
 Assessment of the Quality and Patient Safety Plan12
 Patient Safety Checklists and Patient Safety Policies13
 Approval of Patient Safety Plan15
 Reference.....15
 Appendix A: Terms and Definitions16
 Appendix B: Master Study List.....18
 Appendix C-1: Safety Checklist/Time-Out20
 Appendix C-2: Surgical Handoff21
 Appendix C-3: 10-Element QI Study Template 22
 Appendix D: Policies23

Commitment to Patient Safety

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

Mission, Vision, and Values

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

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

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

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

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

Patient Safety and Quality Improvement Plan

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

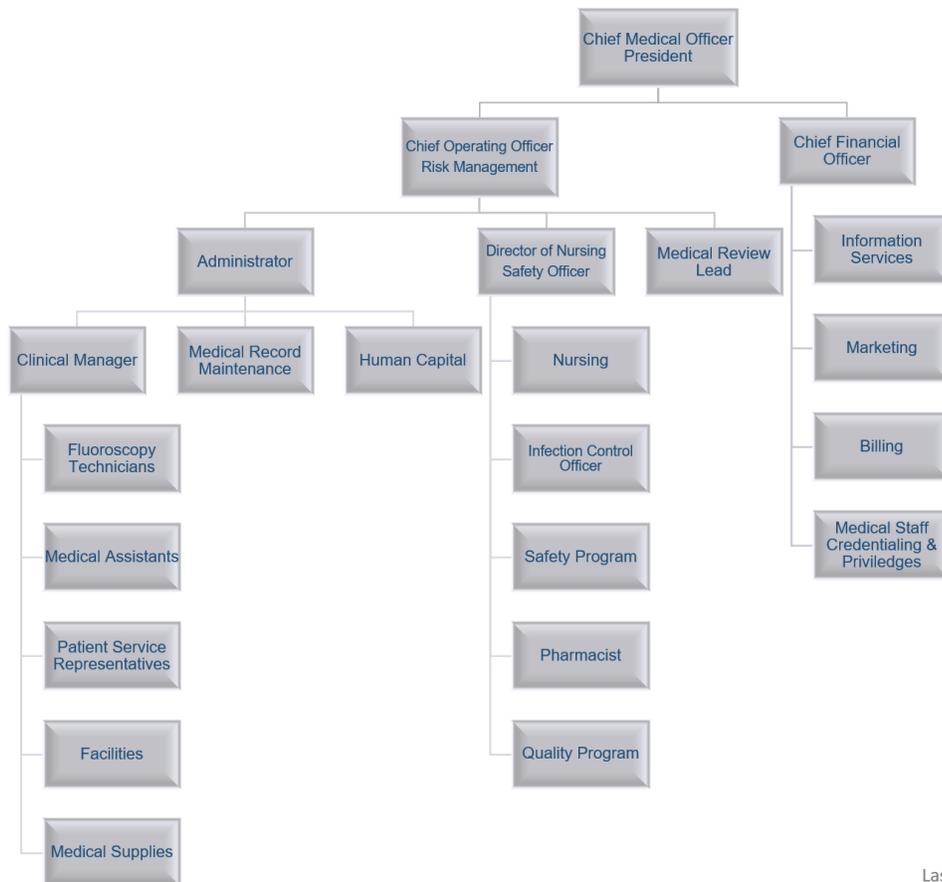
Roles and Responsibilities

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

The Patient Safety Committee Organization



Organizational Chart



Last Revised: 03-01-2018

Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:

Patient Safety and Quality Improvement Plan

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

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

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

The roles and responsibilities are defined below:

- Member 1: Medical Provider, Governing Board Member, Executive Team Member
- Member 2: Governing Board Member, Billing Manger
- Member 3: Governing Board Member, Pharmacist
- Member 4: Medical Provider, Governing Board Member, Executive Team Member
- Member 5: Clinical Manager
- Member 6: Chief Financial Officer, Governing Board Member, Executive Team Member
- Member 7: Governing Board Member, Director of Nursing, Infection Control & Safety Officer
- Member 8: Governing Board Member, Administrator

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

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

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

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

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

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

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

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

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

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Medication Reconciliation	Increase accuracy to ≥ 70%	Increase chart audits with focused training	12-31-2019	Pharmacist
Allergy Documentation	Increase accuracy to ≥ 70%	Continue chart audits with focused training	12-31-2019	Pharmacist
Hand Washing	90% compliance	Observations, training	12-31-2019	Nurse Manager

Components and Methods

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

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



Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Nevada Surgical Suites to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

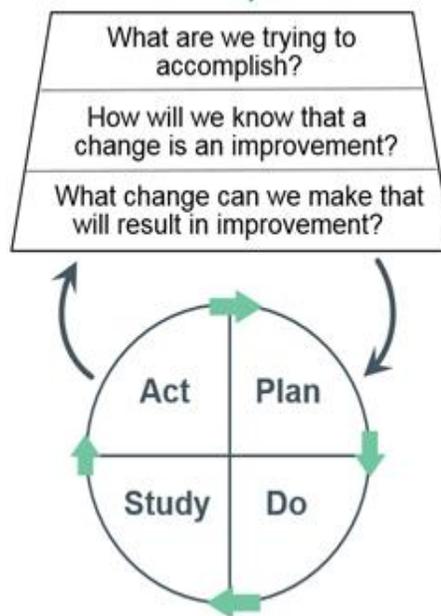
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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



The cycle is defined as follows:

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

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

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

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

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Nevada Surgical Suites is using (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

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

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

- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Quality and Patient Safety Plan is updated annually and submitted through the REDcap Sentinel Event Registry after approval by the organization governing board.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E**.)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.) <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);

- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_ENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Master Study List

Master Study List – Quality Improvement Initiatives

(Infection Control, Patient Safety, Process Improvement)

Calendar Year/ Study Name	Start Date	Completion Date	Re-Assessment Date	Comments	
2015 Study					
1	AAAHC Low Back Injection	01/2015	06/2015	Move to 2016	Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2015	12/2015	Move to 2016	Room for improvement – Study in 2016
3	Handwashing	01/2015	12/2015	Move to 2016	Room for improvement – Study in 2016
2016 Study					
1	AAAHC Low Back Injection	07/2016	12/2016	Move to 2017	Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2016	12/2016	Move to 2017	Room for improvement – Study in 2017
3	Handwashing	01/2016	12/2016	Move to 2017	Performing well – will not study in 2017
2017 Study					
1	AAAHC Low Back Study	04/2017	12/2017	Move to 2018	Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2017	12/2017	Move to 2018	Room for improvement – Study in 2018
3	Q1 2017 ASCA Benchmarking	01/2017	03/2017	Move to Q2	Limited
4	Q2 2017 ASCA Benchmarking	04/2017	06/2017	Move to Q3	Limited
5	Q3 2017 ASCA Benchmarking	07/2017	09/2017	Move to Q4	Limited
6	Q4 2017 ASCA Benchmarking	10/2017	12/2017	Move to 2018	Hold for future reconsideration
2018 Study					
1	Hand Hygiene	01/2018	12/2018	Move to 2019	Room for improvement – Study in 2019
2	AAAHC Low Back Study	01/2018	06/2018	Move to 2019	Evaluating clinical performance measurement and improvement opportunities

3	Medication Reconciliation	01/2018	12/2018	Move to 2019	Room for improvement – Study in 2019
2019 Study					
1	AAAHC Low Back Study	04/2019	12/2019	Planned	Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2019	12/2019	In Progress	Continued improvement need from 2018
3	Handwashing	01/2019	12/2019	In Progress	Continued improvement need from 2018
2020 Study					
1					
2					
3					
4					
5					

Appendix C-1: Safety Check List/ Time-Out



Safety Checklist

Patient:

Area	Done By	Patient or caregiver response
Sedation	<input type="checkbox"/> No Sedation	<input type="checkbox"/> 1. Pt/allergies/procedure confirmed. <input type="checkbox"/> 2. Pt. Verbalizes understanding of anesthesia options. <input type="checkbox"/> 3. Pt. Verbalizes understanding of anesthesia and possible post op pain
Operating Room		<input type="checkbox"/> 1. Pt/allergies/Procedure confirmed. <input type="checkbox"/> 2. Pt. verbalizes adequate understanding of procedure.
<input type="checkbox"/>	Pt. to RN with RN Assistance	<input type="checkbox"/> Ambulates <input type="checkbox"/> Stretcher <input type="checkbox"/> WC
<input type="checkbox"/>	Pt. is positioned upon the O.R. Table and safety strap(s) in use and necessary pillows/cushioning are in place.	<input type="checkbox"/> Prone <input type="checkbox"/> Supine <input type="checkbox"/> R Lateral <input type="checkbox"/> L Lateral
<input type="checkbox"/>	PREP site with:	<input type="checkbox"/> Chloraprep <input type="checkbox"/> Alcohol-prep with No Reaction noted
<input type="checkbox"/>	"TIMEOUT" Conducted to confirm proper patient, procedure, allergies and site	
<input type="checkbox"/>	Procedure Start time:	
<input type="checkbox"/>	Medications injected:	<input type="checkbox"/> Dexamethasone <input type="checkbox"/> Lidocaine <input type="checkbox"/> Marcaine (0.5) (0.25) <input type="checkbox"/> Omnipaque <input type="checkbox"/> Magnevist
<input type="checkbox"/>	Radio Frequency ground pad site:	<input type="checkbox"/> R / L Posterolateral thigh <input type="checkbox"/> R / L posterior thoracic <input type="checkbox"/> R / L Posterolateral buttocks
<input type="checkbox"/>	Radio Frequency Probe(s) Serial Number:	
<input type="checkbox"/>	SCS Trial/Implant Lot Number:	
<input type="checkbox"/>	SCS Trial/Implant Serial Number:	
<input type="checkbox"/>	Pt Tolerated procedure without complications	
<input type="checkbox"/>	Pt Transported via:	<input type="checkbox"/> stretcher (side rails up) <input type="checkbox"/> WC
<input type="checkbox"/>	Procedure End time:	
<input type="checkbox"/>	Pt. transferred to PACU without incident. Time:	

07/20/17 NSS

Appendix C-2: Surgical Handoff



PREPROCEDURE CHECK-IN	SIGN-IN	TIME-OUT	SIGN-OUT
Patient Received by Pre-op RN _____	Patient Received by Intra-op RN _____ Time _____	Time-out _____	Patient received by Post-op RN _____
In Holding Area	Before Induction of Anesthesia	Before Skin Incision	Before the Patient Leaves the Operating Room
Patient/patient representative actively confirms with Registered Nurse (RN):	RN and anesthesia care provider confirm:	Initiated by designated team member All other activities to be suspended (unless a life-threatening emergency)	RN confirms:
Identity <input type="checkbox"/> Yes Procedure and procedure site <input type="checkbox"/> Yes Consent(s) <input type="checkbox"/> Yes <input type="checkbox"/> N/A Site marked <input type="checkbox"/> Yes <input type="checkbox"/> N/A by person performing the procedure RN confirms presence of: History and physical <input type="checkbox"/> Yes Preanesthesia assessment <input type="checkbox"/> Yes Any special equipment, devices, implants <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Confirmation of: identity, procedure, procedure site and consent(s) <input type="checkbox"/> Yes Site marked <input type="checkbox"/> Yes <input type="checkbox"/> N/A by person performing the procedure Patient allergies <input type="checkbox"/> Yes <input type="checkbox"/> N/A Difficult airway or aspiration risk? <input type="checkbox"/> No <input type="checkbox"/> Yes (preparation confirmed) Anesthesia safety check completed <input type="checkbox"/> Yes Briefing: All members of the team have discussed care plan and addressed concerns <input type="checkbox"/> Yes	All: Confirmation of the following: identity, procedure, incision site, consent(s) <input type="checkbox"/> Yes Site is marked and visible <input type="checkbox"/> Yes <input type="checkbox"/> N/A Relevant images properly labeled and displayed <input type="checkbox"/> Yes <input type="checkbox"/> N/A Any equipment concerns? Anesthesia Provider: <input type="checkbox"/> Antibiotic prophylaxis before incision <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> Additional concerns? Scrub and circulating nurse: <input type="checkbox"/> Sterilization indicators have been confirmed <input type="checkbox"/> Additional concerns?	Name of operative procedure Any equipment problems to be addressed? <input type="checkbox"/> Yes <input type="checkbox"/> N/A

Surgical Handoff

12/06/2016 NSS

Appendix D: Policies

Chapter 5: Quality and Risk management

Chapter 7 Sub-Chapter 1 & 2: Infection Control and Safety

Chapter 8: Emergency Preparedness



Sunset Surgery Center
Infection Control Guidelines
Revised 1/29/2018

Sunset Surgery Center
INFECTION CONTROL POLICY

This policy is consistent with Centers for Disease Control Recommendations for Standard Precautions. The policy is established to maintain a program for the prevention and control of infections and communicable diseases.

A. General Principles

1. Designed to reduce possible infection while performing surgical procedures as outlined in our policies and procedures.
2. Takes into consideration the health status of our patients.
3. Consider all patients' blood, and bodily fluids as infectious materials.
4. In order to reduce the possibility of infection we hold a 2:1 Nurse to Patient ratio. All RN's are licensed in the state of Nevada.
5. Equipment, instruments, and utensils which come in contact with patient excretions, secretions and bodily fluids are considered contaminated.
6. Infectious waste includes, but is not limited to, the following:
 - a. All dressings
 - b. Used soiled pads/diapers
 - c. Intravenous tubing/catheters
 - d. All used needles/sharps

- e. Trash, gloves, gowns, masks, etc. from isolation room.
- f. Sanitary napkins
- g. Used suction containers and tubing
- h. Specimens
- i. Disposable equipment and supplies once used on a patient
- j. Endotracheal tube, laryngoscope blades, airways

B. Precautions

All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. The purpose of protective equipment is to keep blood and other potentially infectious material from contacting skin, eyes, and mucous membranes. In some cases, adequate protection is provided solely by gloves. In other cases, masks and eye protection will also be needed. And in still other situations, gowns, aprons, and head covering may be required. All staff will be trained on an annual basis and retrained if needed.

C. Procedures

1. Wash hands frequently and always between patients and after glove removal. Gloves should be changed after contact with each patient and immediately if they're torn or punctured.
2. Wear gloves when exposed to any patient's blood and body excretions and/or secretions such as when touching mucous membranes or non-intact skin, handling soiled equipment or vascular access procedures such as finger or heel sticks and venipunctures. (Other examples include):
 - a. Collecting specimens
 - b. Cleaning up fecal/urinary incontinence or handling linen and soiled garments
 - c. Bathing a patient
 - d. Mouth care and eye care
 - e. Removing soiled bed linens

- f. Beginning/discontinuing/converting intravenous and intraosseous therapies
 - g. Administering parenteral injections
 - h. Emptying Foleys, bedpans, urinals, emesis basins, NG drainage and wound drainage, sitz baths
 - i. Changing dressings, perineal pads, and diapers
 - j. Cleaning any surface the patient has contact with, spills of blood or body fluids
 - k. Handling tissues or clothing contaminated with tears or perspiration
 - l. Performing suctioning or intubation
3. Place disposable syringes and needles, scalpel blades, and other sharp items into designated, puncture-resistant containers. Do not recap, bend or break off needles.
 4. Place all infectious waste not suitable for disposal in "sharps" container into red (biohazard) plastic bags.
 5. Wear gowns if splashing or soiling by blood and body fluids is likely. After exposure, remove protective clothing to avoid contaminating self. Place in the assigned area or container.
 6. Wear other protective covering (e.g. masks, goggles, face shields, etc.) as indicated by particular situations such as patients with infections, during invasive procedures, or when splashing is likely. Wash after removing protective equipment and as soon as possible after blood contact with skin, eyes, or mucous membranes.
 7. Individuals with exudative lesions or exposed skin surfaces should refrain from direct patient care and from handling patient-care equipment. Small cuts and scrapes should be covered with an occlusive adhesive dressing or bandage and monitored closely for integrity during patient care activities.

D. CPR

Although saliva has not been implicated in HIV transmission, mouth-to-mouth resuscitation should not be performed. Use available resuscitation bags, mouthpieces and ventilation devices when resuscitating patients.

E. Exposure Incident

1. A significant exposure is defined as:
 - a. A needle stick or cut caused by a needle or sharp that was actually or potentially contaminated with blood or body fluids.
 - b. A mucous membrane exposure (i.e. splash to the eye or mouth) to blood or body fluids.
 - c. A cutaneous exposure involving large amounts of blood or prolonged contact with blood- especially when the exposed skin was chapped, abraded, or afflicted with dermatitis.

If you are directly exposed, **report it immediately** to your supervisor.

2. Use a specific solution such as alcohol or Fertisafe if contaminated with blood or body fluids from a patient with, or at risk for, HIV infection, Hepatitis B or C virus.
3. If an accidental exposure occurs staff should follow CDC guidelines for occupational exposure: if needle stick, test for HIV to establish seronegativity first, then retest at 6 weeks, 3 months, 6 months, and 1 year.
4. You will be directed to your personal physician for any treatment and follow-up required as a result of any exposure you encounter. Sunset Surgery Center is not responsible for covering the costs of any associated treatments. Employees are strongly urged to obtain their own health insurance.



Department of Health Notification

Purpose: To comply with the Department of Health's regulations for notification.

Procedure:

1. If our health care facility is aware of information which shows that the facility is not in compliance with any of the Department's regulations applicable to our health care facility, and that noncompliance seriously compromises quality assurance or patient safety, we will immediately act to correct the noncompliance.
2. If our health care facility is aware of a situation or the occurrence of an event at our facility which could seriously compromise quality assurance or patient safety, we will follow all laws requiring proper notification of proper authorities. The notification will include sufficient detail and information to alert the Department as to the reason for its occurrence and the steps that our health care facility will take to rectify the situation.
3. For purposes of subsections, (1) and (2) events which seriously compromise quality assurance or patient safety include, but are not limited to, the following:
 - a. Deaths occurring at the facility.
 - b. Rape occurring at the facility.
 - c. Surgery performed on the wrong patient or on the wrong body part.
 - d. Notification of termination of any services vital to the continued safe operation of the facility or the health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer and local exchange telephone service.
 - e. Unlicensed practice of a regulated professional.



Policy: Mandatory Reporting of Infectious Diseases by Clinicians/Lab Personnel

It is the policy of all Employees at SSC to adhere to the Nevada State and Local laws regarding the mandatory reporting of infectious diseases and infectious disease-related conditions to the appropriate state health departments and Centers for Disease Control.

Nevada State Department and Human Resources Division of Health

505 E. King St. Room 201

Capitol Complex

Carson City, NV 89710

Phone: 1-702-885-4740

I adhere to the State and Local policies of reporting infectious disease and infectious disease related conditions to the appropriate state health departments and CDC.



Airborne precautions

Purpose: To provide guidance to perioperative personnel for using and implementing airborne precautions if necessary in perioperative areas.

Policy: Elective surgery will be postponed for perioperative patients requiring airborne precautions until the patient is determined to be noninfectious.

Procedure:

- A. The following steps will be followed when using and implementing airborne precautions for perioperative patients:
 - a. When a patient suspected of measles infection enters the facility, all personnel will use respiratory protection if available.
 - b. When a patient with confirmed or suspected varicella infection enters the facility, airborne and contact precautions will be implemented and followed, and only personnel with evidence of immunity will provide care to the patient.
 - c. When caring for a perioperative patient who requires airborne precautions, perioperative personnel will don a surgical mask or an N95 respirator, depending on the disease-specific recommendations, before entering the room of the patient don personal protective equipment (PPE) before entering the room discard PPE and perform hand hygiene when exiting the room.
 - d. Infected skin lesions will be covered and contained.
 - e. Standard cleaning and disinfection procedures will be followed after surgery on a patient requiring airborne precautions, but only after the appropriate amount of time for air ventilation.
 - i. Personal respiratory protective equipment is not necessary for cleaning an OR if the appropriate ventilation time has been allowed.
 - ii. If room cleaning activities must begin before the appropriate amount of time for air ventilation, cleaning personnel will wear an N95 or powered air-purifying respirator.
 - f. When transporting perioperative patients who require airborne precautions from an airborne infection isolation room to the OR, the patient will wear a surgical mask if clinically appropriate.
 - i. Patients will be transported directly to the OR, bypassing the preoperative area, and at the end of the procedure transferred directly to an airborne infection isolation room in the post anesthesia care unit or other designated area of the facility.
 - g. Documentation
 - i. The perioperative RN will document in the patient's chart the care of the patient known or suspected to be infected or colonized with microorganisms that are transmitted by airborne droplet nuclei and the physiologic responses throughout the continuum of care, including patient assessment, plan of care, nursing diagnoses, desired outcomes, and interventions.



Contact precautions

Purpose: To provide guidance to perioperative personnel for using and implementing contact precautions in perioperative areas. The expected outcome is that the patient will be free from signs and symptoms of infection

Policy:

- A. It is the policy of Sunset Surgery Center not to schedule patients who are known or suspected to be infected or colonized with microorganisms that are transmitted by direct or indirect contact (eg, methicillin-resistant *Staphylococcus aureus*, vancomycin-resistant *Enterococci*, *Clostridium difficile*).
- B. An infection preventionist will be consulted for guidance when measures are indicated to prevent the spread of highly transmissible or epidemiologically important pathogens.

Procedure:

- A. If a patient is discovered to have a potential infection, contact precautions by the staff will be mandatory.
- B. When caring for a patient who requires contact precautions, perioperative personnel will don personal protective equipment (PPE) before entering the room and discard PPE and perform hand hygiene when exiting the room.
- C. When patient transport is necessary, precautions will be taken to reduce the opportunity for transmission of microorganisms to other patients, personnel, and visitors, and to reduce contamination of the environment.
 - a. Use appropriate barriers to cover affected areas if infectious skin lesions or drainage are present.
 - b. Before transporting the patient:
 - c. The perioperative nurse will notify the receiving team members that the patient is coming and what precautions to take to prevent transmission.
 - i. Contaminated PPE will be removed and discarded and then hand hygiene performed.
 - ii. Clean PPE will be donned to handle the patient at the transport destination.
- D. Unscrubbed personnel (eg, anesthesia professionals, circulating RNs) will wear gloves whenever touching the patient's skin or items that are in close proximity to the patient, wear a gown when it can be anticipated that clothing will come into contact with the patient or contaminated environmental surfaces, don a gown before entering the room, and remove the gown and perform hand hygiene when exiting the room.
- E. Preoperative personnel will hold the patient in a single patient room, if possible, or keep a separation of at least 3 feet between patients.
- F. Environmental cleaning will be implemented to help control the spread of microorganisms that are transmitted by direct or indirect contact.



- a. Routine cleaning of perioperative environmental surfaces (eg, floors, walls) will be performed according to Terminal Cleaning Policy.
 - b. Thorough cleaning and disinfection practices will be implemented for frequently touched surfaces (eg, bedrails, doorknobs).
 - c. All noncritical equipment (eg, IV pumps, ventilators) will be cleaned and disinfected before use on another patient and will be handled in a manner to prevent provider or environmental contact with potentially infectious materials.
 - i. Dedicated noncritical items such as stethoscopes, blood pressure cuffs, and electronic thermometers may be used.
- G. Perioperative RNs will evaluate and manage any negative patient outcomes potentially caused by using contact precautions (eg, reduced patient-to-provider contact, increased symptoms of depression and anxiety, decreased satisfaction with care).

Documentation:

- A. The perioperative RN will document the care of the patient known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact or indirect contact and the physiologic responses throughout the continuum of care, including: patient assessment, plan of care, nursing diagnoses, desired outcomes, and interventions.



Tuberculosis precautions

Purpose: To establish guidelines to identify and handle tuberculosis within the facility..

Reference: U. S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC) Recommendations and Reports (December 30, 2005, 54 (#RR-17):i-147), Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings.

Definitions: None

Policy: Sunset Surgery Center will not knowingly admit a patient with tuberculosis or similar symptoms.

1. Signs and Symptoms of tuberculosis include:
 - a. A cough lasting for three (3) weeks or longer
 - b. Bloody sputum
 - c. Chest pain
 - d. Night sweats
 - e. Weight Loss
 - f. Anorexia
 - g. Fever
 - h. Easily fatigued
2. Susceptible groups include:
 - a. Medically under-served populations including some African-Americans, Hispanics,
 - b. Asians and Pacific Islanders, American Indians and Alaskan Natives
 - c. Homeless persons
 - d. Current or past prison inmates
 - e. Alcoholics
 - f. Intravenous (IV) drug users
 - g. Elderly
 - h. Foreign-born persons from Asia, Africa, the Caribbean, Latin America and the former
 - i. Soviet Republic areas
 - j. Contacts with persons having active TB
 - k. Chronic steroid use (as in arthritis patients)
3. All employees and physicians are required to have tuberculosis screening annually.
4. All new employees must present tuberculosis screening within 10 days of employment.
5. All physicians practicing within the Center must maintain annual screening for tuberculosis.



Procedure:

- A. All patients are screened by the referring physician prior to surgery. If it is discovered that a patient has been diagnosed or shows potential symptoms, any surgical procedures will be cancelled. Once the patient is free from all signs/symptoms, the surgery can be rescheduled.
- B. Any patient suspected to have tuberculosis will be masked and transported to the hospital for treatment in an Isola.
- C. Clinic receptionist staff should immediately notify the nurse if they observe patient or visitor in the lobby exhibiting suspicious respiratory symptoms. Patients suspected of, or known to have active TB should be given a surgical mask and be shown how to wear it. All patients should be asked to cover their mouth and nose with tissues when coughing/sneezing and dispose of used tissues in a lined trash receptacle. Arrangements should be made to transfer the patient to an appropriate isolation room as soon as possible.
- D. Any employee suspected of tuberculosis will be suspended until such treatment can be completed and all signs/symptoms are resolved.
- E. If the employee fails to show proof of tuberculosis screening, they will be suspended until current proof can be provided.
- F. If a possible exposure is reported by an employee:
- G. Employees with previous negative TB tests:
 - a. All previous negative reactor employees should have a baseline TB skin test done as soon as possible after an exposure has occurred.
 - b. Eight to Ten weeks after the exposure, these employees should be retested and assessed for conversion.
 - c. If an employee begins showing symptoms of active TB, the Infection Control Nurse should be notified immediately.
- H. Employees with previous positive TB tests:
 - a. TB Questionnaire will be done as soon as possible after exposure.
 - b. Eight to Ten weeks after a TB exposure, employees should complete a follow-up TB Questionnaire.
 - c. If an employee begins showing symptoms of active TB or notes positive symptoms on the TB Questionnaire, the Infection Control Nurse (or designee) should be notified immediately.

Documentation:

- A. If a procedure is cancelled due to suspected tuberculosis, it is to be documented in the patient's chart
- B. All proof of employee and physician's tuberculosis screening is to be filed in their medical chart.
- C. If exposure is discovered, an Event Report will be documented and the employee will be sent for Medical treatment



SUNSET SURGERY CENTER
INFECTION CONTROL
EMPLOYEE COMMUNICABLE DISEASE POLICY

**CATEGORY: INFECTION CONTROL PRECAUTIONS FOR EMPLOYEES
WITH COMMUNICABLE DISEASE**

PURPOSE: The purpose of this policy is to control and prevent the spread of communicable disease from employees in the health care setting to patients, visitors, other employees and third parties. Sunset Surgery Center Infection Control will monitor those employees or contract employees who have an unscheduled absence. The CDC guidelines on communicable diseases will be followed to determine when an employee on contract employee is free of communicable disease and may return to work.

PROCEDURE:

1. An employee is required to follow department guidelines when due to a medical reason he/she is unable to work as scheduled. The employee will be advised to follow the communicable disease policy if symptomatic of infectious disease(s).
2. Department managers are responsible for having a sick call-in process in place to identify employees with signs and symptoms of communicable diseases. Infection Control is available for consultation (Julie Smink, R.N.)
3. Employees and contract employees are to notify Infection Control immediately if diagnosed with one of the diseases listed or if he/she develops symptoms of an infectious/communicable disease.

4. An employee who is absent due to communicable disease must be deemed free of the communicable disease and/or non-transmissible to others at the work place before returning to work. Infection Control will notify the manager that the employee is required to have return to work permission from IC. IC will not disclose the disease to the manager.
5. CDC Guidelines will be posted in each department for determining when an employee is free of communicable disease.
6. All employees who report a communicable disease medical diagnosis to Infection Control, are required to comply with the IC instructions for return to work.
7. Managers will not allow any employee on restriction from IC to work until notified by IC that the employee is allowed to return to work.
8. All employees are required to read this policy and attachments, which list all the communicable disease that must be reported to the manager and Infection Control Coordinator. Review of this policy will be done at the time of hire or before providing patient care services, and an acknowledgement will be signed at the time. An annual review will be conducted of all employees.
 - a. Infection Control will log and document all communicable disease process, reported by all employees.
 - b. All managers will notify the Infection Control Coordinator of unusual occurrences or trends in communicable disease occurrence that require further investigation.
 - c. Infection Control will report occurrences by listed disease annually to the Infection Control and Safety Committee and provide an evaluation of the program's effectiveness.



INFECTION CONTROL

MANAGEMENT RESPONSIBILITIES

1. Teach employees that all patients' blood and body fluids are considered potentially infectious for human immunodeficiency virus (HIV), hepatitis B (HBV), hepatitis C (HCV) and other blood borne pathogens.
2. Provide a general explanation of the epidemiology, modes of transmission, and symptoms of blood borne pathogens. Exposure incidents can lead to infection from HIV, HBV, or HCV. Early symptoms of HIV include: fever, sore throat, lethargy, swollen glands. Early symptoms of HBV are: fever, runny nose, flu-like symptoms, skin rash, loss of appetite, fatigue, headache, nausea, vomiting, and diarrhea.
3. Demonstrate/describe protective barriers such as gloves, gowns, goggles and masks/face shields including use, location, removal, handling, decontamination, and disposal of personal protective equipment.
4. Emphasize that it is mandatory that Standard Precautions be followed as outlined in the Infection Control Policy.
5. Provide information on appropriate actions to take if an exposure incident occurs including the method of reporting that incident and the medical follow-up.
 - Document the circumstances of the incident and route of exposure.
 - The source individual's blood is tested for HIV, HBV, and HCV as soon as feasible, after consent is obtained.
 - The results of the source individual's blood test are made available to the exposed person.
 - The exposed person's blood is collected as soon as practical and tested after consent is obtained.
 - Post-exposure follow-up may be indicated.
6. Provide an opportunity for interactive questions and answers. Management must work closely with inexperienced staff and choose assignments for which the employee is prepared in terms of both knowledge and skill level.

7. Management and staff should understand and follow rules of confidentiality pertaining to test results and health records.
8. Career counseling should be initiated in a situation in which an employee refused to care for any client.



Sunset Surgery Center
EXPOSURE CONTROL PLAN
For
PROCEDURE SKILLS

Employee Preparation

Employees attend a required practice session to prepare for this skill.

A review of precautions includes instructing employees to wash their hands thoroughly with soap and water and to wear gloves.

After "sharps" are used, the invasive piece of equipment is placed in a standard hospital "sharps" box. Supplies are "red bagged." Contaminated materials are disposed of at an approved site at the end of the day or as needed.

If suspected contamination occurs, the employee is instructed to soak the area with a 1:50 Clorox solution followed by thoroughly washing with soap and water. He/she is then referred to his/her physician or health care agency for follow-up testing. An incident report is filed through the program coordinator/director. Sunset Surgery Center is not responsible for covering the costs of any associated testing or treatments. Employees are strongly urged to obtain their own health insurance.



Sunset Surgery Center

OCCUPATIONAL EXPOSURE INFECTION CONTROL POLICY

CATEGORY: PREVENTING TRANSMISSION OF PATHOGENIC MICROORGANISMS

SUBJECT: HAND HYGIENE

DEFINITION:

A general term that applies to hand wash, antiseptic hand rub or surgical hand antisepsis.

The major concern of any infection control program is the prevention of infection. Because many types of infections may be caused by organisms transmitted on the hands of healthcare personnel, *hand hygiene is generally considered the single most important procedure in preventing the spread of infection.* For this reason guidelines are being provided for the use of appropriate hand hygiene procedures.

General Information: This includes patient care and non-patient care areas.

1. Hands are washed when visibly soiled with either an antimicrobial soap or a regular soap and tepid water. (Hot water can irritate skin.)
 2. An alcohol based hand sanitizer product (60-95% alcohol) can be utilized if hands are not visible soiled. This kind of product is not appropriate for use when hands are visibly dirty or contaminated with proteinaceous material.
-
- I. Non-patient Contact Areas (e.g. public rest rooms, break rooms, laboratories and/or other research areas, etc.)
 - a. Hand-washing facilities including sinks with running water (hot and cold), waste receptacles, soap and disposable paper towel dispensers should be conveniently located for frequent use by all personnel.
 - b. A hand washing product that is generally acceptable to personnel is to be provided.
 - c. Hand washing is done after going to the bathroom, before eating, etc.

 - II. Patient Care Areas
 - a. Hand-washing facilities including sinks with running water (hot and cold), waste receptacles, soap, and disposable paper towel dispensers should be conveniently located for frequent use by personnel.
 - b. For routine patient contacts and procedures, cleaning of patient care equipment involves a vigorous rubbing together of all surfaces of soap lathered hands for at least

fifteen seconds, followed by a rinsing under a stream of water is recommended, using a product which is generally acceptable to personnel. After drying hands thoroughly with a disposable paper towel, discard the used paper towel in the waste receptacle and use a dry paper towel to turn off faucets and open the exam room door.

Rationale: Using a wet paper towel to turn off faucets and open exam room doors creates a "strike through" where bacteria on these surfaces can cross over the wet paper towel and re-contaminate clean hands.

- c. In the absence of a true emergency, personnel must always wash their hands, even when gloves are used:
 1. Before putting on gloves and after removing gloves.
 2. Before direct care of patients when the potential for contamination by blood/body fluids exists. This is mandated by OSHA.
 3. After contact with intact skin such as after taking blood pressure, lifting patients, taking temperatures, etc. This prevents cross-examination from one site to another on the patient. (Patients carry microorganisms on their intact skin and may be colonized with infectious microbes.)
 4. Before performing invasive procedures, such as urinary catheter placement or manipulations, peripheral intravenous line placement, etc.
 5. Before taking care of particularly susceptible patients, such as those who are severely immune-compromised (HIV, transplant, chemotherapy, radiation patients, etc.) and newborns.
 6. Before and after touching wounds, whether surgical, traumatic, or associated with an invasive device.
 7. After situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood or body fluids, secretions, or excretions.
 8. After touching inanimate sources that are likely to be contaminated with virulent or epidemiologically important microorganisms. These sources include urinary measuring devices or secretion collection apparatus, and any inanimate objects in immediate vicinity of patients (e.g. exam tables, chairs, sinks, desk tops, etc.)
 9. After taking care of an infected patient or one who is likely to be colonized with microorganisms of special clinical or epidemiological significance; i.e. multiply-resistant organisms.
 10. Between tasks and procedures in the same patient to prevent cross contamination of different body sites-- such as wound dressing and then placing a peripheral IV site.
 11. Between contacts with different patients.
 12. After gloves are removed.

- d. Healthcare worker's fingernails
 1. Healthcare workers working in patient care areas must not wear artificial fingernails or nail extenders.

2. Healthcare workers working in patient care areas must keep natural nail tips at or less than $\frac{1}{4}$ of an inch long.
3. Nail polish should be intact. If chipped the nail polish should be removed.
4. No current recommendation can be made regarding wearing rings in health-care settings. This is an unresolved issue at present.



Sunset Surgery Center
HANDWASHING TECHNIQUE

1. If necessary, push up sleeves and your watch.
2. Turn faucets on and adjust water to as warm a temperature as you can tolerate.
3. Wet hands with water. Spread a thin film of soap over the entire skin surface. Wash thoroughly, rubbing all the surfaces of the hands together briskly for at least 30 seconds.
4. Rinse under running water with hands pointed downwards.
5. Dry with paper towels.
6. Turn off faucets using a dry paper towel and use a paper towel to open the door to exit.

Examples of: WHEN TO WASH YOUR HANDS

1. Before beginning work.
2. Before and after caring for each patient.
3. After collecting a urine specimen, giving a bedpan, or handling a commode.

4. After sneezing or coughing into your hand or using a Kleenex.
5. Before and after taking a temperature, either oral or rectal.
6. Before eating.
7. Before and after using the bathroom.
8. After any contaminated contact.
9. After finishing work—before leaving.

Sunset Surgery Center

PROCEDURES FOR HAND HYGIENE

A. Hand washing procedure for soap and water:

1. When washing hands with soap and water, wet hands first with water (preferably warm water), apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously covering all surfaces of hands and fingers and around fingernails.
2. Rinse hands with water and dry thoroughly with a disposable towel. Dispose of wet paper towel in waste receptacle.
3. Use dry towel to turn off the faucets and to open exam room door or restroom door.
4. Avoid using hot water because repeated exposure to hot water may increase the risk of dermatitis.

B. Hand hygiene with alcohol based products for routine care:

1. When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers until hands are dry.
2. Follow the manufacturer's recommendations regarding the volume of product to use.
3. Store supplies of alcohol-based hand rubs in cabinets or areas approved for flammable materials.

Hands contaminated with spores such as bacillus anthracis (anthrax) should be washed with soap and water; because alcohol based products as well as other antiseptics have poor activity against spores.

Antiseptics

- A. Antiseptics used in the clinics and research areas/laboratories must be approved by the Infection Control and Safety Committee.
- B. All hand soaps have antimicrobial activity.
- C. Antiseptics are used to decontaminate the skin and other superficial tissues. They do not sterilize the skin but they can reduce microbial contamination depending on the amount and type of contamination, the antiseptic agent

used, the length of exposure to the agent, the presence of residual activity and the technique used.

- D. Alcohol based antiseptics, hand sanitizers that do not require water to use (e.g. foams, gels, and rinses) are adjuncts for either hand washing or the surgical scrub. However, these products may be used in the following instances:
1. As a supplement to the surgical scrub (applied after the first routine scrub for identical procedures).
 2. In the event that there is no soap and running warm water available.
 3. De-germing of hands after gloves are removed in the procedure/patient exam room cleaning process.
 4. Hands must be visibly free of soil/debris.
 5. Hands must be washed with soap and running warm water after the alcohol based hand sanitizer/antiseptic is used two or three consecutive times, based on the manufacturer's guidelines for their prospective products.
- E. Antiseptics approved by the Infection Control and Safety Committee for hand scrubs are:
1. Alcohol
 2. Alcohol gels or foams (at least 60-95% alcohol)
 3. 4% chlorhexidine gluconate
 4. Hexachlorophene
 5. Iodine/Iodophors
 6. Para-chloro-meta-xylene (PCMX)
 7. Triclosan (or Irgasan DP-300)

References:

1. Centers for Disease Control, "Guidelines for Hand washing". Website: www.cdc.gov
2. APIC Guidelines for Infection Control Practice, "Guideline for Use of Topical Antimicrobial Agents", Larson, Ed, 1988. Website: www.apic.org
3. APIC Guideline for Hand Hygiene in Health-Care Settings, "Recommendations Of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force"

Sunset Surgery Center

COMMUNICABLE DISEASE POLICY FOR EMPLOYEES: LIST OF DISEASES

CALL INFECTION CONTROL COORDINATOR IF YOU ARE DIAGNOSED WITH ANY OF THE FOLLOWING ILLNESSES:

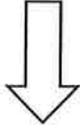
Diseases named as or caused by:

- Chicken pox
- Chicken pox, if you have been exposed and not had Chicken pox
- Diarrhea caused by Amebiasis, Cholera, Cryptosporidiosis, E. coli 0-157, Giardia, Salmonella, Shigella, C. Diff.
- Draining wound caused by Staphylococcus aureus (both MRSA/MSSA)
- Hepatitis A
- Herpes simplex on the hand- like a cold sore on the hand
- Impetigo
- Influenza
- Lice
- Measles
- Mumps, active
- Mumps, if you have been exposed and not had Mumps
- Pink eye- conjunctivitis (viral)
- Resistant organisms colonized or infected such as MRSA, VRE, others
- Rubella, active
- Rubella, if you have been exposed and not had Rubella
- Scabies
- Shingles
- Shingles, if you have been exposed and not had Chicken pox
- Strep throat caused by Group A Streptococcus
- Tuberculosis (TB)
- Anthrax
- Boils caused by Staphylococcus aureus (Staph)
- Brucellosis
- Diphtheria
- Leprosy (Hansen disease)
- Meningitis caused by Neisseria meningitis
- Typhoid fever
- Whooping cough
- Noro Virus

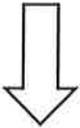
Sunset Surgery Center

COMMUNICABLE DISEASE POLICY FOR EMPLOYEES FLOWCHART OF PROCESS

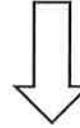
Employee ill at work



Supervisor reminds employee of Communicable Disease Policy and Sends employee home



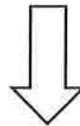
Employee call in ill



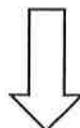
Supervisor reminds employee of Communicable Disease Policy



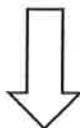
If employee is diagnosed with communicable disease listed he/she is to call immediately. Leave a message if IC is not available. Phone number: (702) 262-0079 ext. 234



Infection Control notifies employee supervisor that employee has restrictions before he/she can return to work.



Employee takes document to meet the disease criteria to return to work to IC prior to returning to work. Copies of document will be given to HR.



IC will notify the employee's supervisor that the employee can return to work.

SUNSET SURGERY CENTER
INFECTION CONTROL
EMPLOYEE COMMUNICABLE DISEASE POLICY

**CATEGORY: INFECTION CONTROL PRECAUTIONS FOR EMPLOYEES
WITH COMMUNICABLE DISEASE**

PURPOSE: The purpose of this policy is to control and prevent the spread of communicable disease from employees in the health care setting to patients, visitors, other employees and third parties. Sunset Surgery Center Infection Control will monitor those employees or contract employees who have an unscheduled absence. The CDC guidelines on communicable diseases will be followed to determine when an employee or contract employee is free of communicable disease and may return to work.

PROCEDURE:

1. An employee is required to follow department guidelines when due to a medical reason he/she is unable to work as scheduled. The employee will be advised to follow the communicable disease policy if symptomatic of infectious disease(s).
2. Department managers are responsible for having a sick call-in process in place to identify employees with signs and symptoms of communicable diseases. Infection Control is available for consultation (Julie Smink, R.N.)
3. Employees and contract employees are to notify Infection Control immediately if diagnosed with one of the diseases listed or if he/she develops symptoms of an infectious/communicable disease.
4. An employee who is absent due to communicable disease must be deemed free of the communicable disease and/or non-transmissible to others at the work place before returning to work. Infection Control will notify the manager that the employee is required to have return to work permission from IC. IC will not disclose the disease to the manager.
5. CDC Guidelines will be posted in each department for determining when an employee is free of communicable disease.
6. All employees who report a communicable disease medical diagnosis to Infection Control, are required to comply with the IC instructions for return to work.

7. Managers will not allow any employee on restriction from IC to work until notified by IC that the employee is allowed to return to work.
8. All employees are required to read this policy and attachments, which list all the communicable disease that must be reported to the manager and Infection Control Coordinator. Review of this policy will be done at the time of hire or before providing patient care services, and an acknowledgement will be signed at the time. An annual review will be conducted of all employees.
 - a. Infection Control will log and document all communicable disease process, reported by all employees.
 - b. All managers will notify the Infection Control Coordinator of unusual occurrences or trends in communicable disease occurrence that require further investigation.
 - c. Infection Control will report occurrences by listed disease annually to the Infection Control and Safety Committee and provide an evaluation of the program's effectiveness.



Contaminated Needle Stick HIV/HIB Awareness Policy

Purpose: To provide for the safety of the employees and patients of the Center.

Policy: A uniform routine will be followed after an occurrence of an employee of the Center being pricked by a contaminated needle.

Procedure:

- Routine:
 1. Break scrub as soon as is compatible with patient safety.
 2. Wash thoroughly with hand scrub solution, "milking" the wound.
 3. Normal wound treatment, including tetanus prophylaxis, if indicated.
 4. Inform patient, or next of kin, and obtain permission for HIV/HIB screening.

- Abraded Skin:
 1. Break scrub as soon as possible.
 2. Clean area thoroughly with scrub solution.
 3. Apply occlusive dressing if further patient contact is necessary.
 4. If mucous membranes exposed (eye, oral, cavity), flush with saline.
 5. Obtain permission from patient, or next of kin, for HIV/HIB screening.

- High Risk Patients:
 1. Break scrub as soon as possible.
 2. Clean area thoroughly.
 3. Inform patient, or next of kin, and obtain permission for HIV/HIB screening.
 4. Obtain personal HIV screening.
 5. Begin AZT 600 mg/day for six weeks.
 6. CBC every two weeks while taking AZT.
 7. If patient not available for further screening (negative HIV), health care worker should be tested at six weeks, twelve weeks, and six months.



Contaminated Patient Policy

Policy:

- Due to the nature of our practice, FDA infectious disease panels are required and performed prior to admission.
- If it is found that the patient is positive for any transmittable/contagious infectious disease, the patient is referred to seek care from their primary care physician and admission to Sunset Surgery Center is at the discretion of the Governing body.
- If admission is approved all universal precautions per the CDC and OSHA are implemented and followed by all staff.



Cleaning Blood and Bodily Fluid Spills and Blood-borne Pathogens

Purpose: A protocol for the proper clean-up of bodily fluids has been universally established to ensure the safety of all those who are potentially exposed. Blood and other bodily fluids should be immediately cleaned up to lessen the danger of spreading HIV and Hepatitis B and C

Principles:

1. All human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other airborne pathogens. (i.e. the concept of Universal Precautions). A bodily fluid spill kit for SSC is kept in the clean room under the sink.

Procedure:

1. Cover the spill with absorbent paper towels to avoid stepping in it.
2. Block off the area of the body fluids spill to prevent further spread.
3. Put on vinyl gloves and carefully wipe up the spill with the paper towels and carefully place the mess in a biohazard bag.
4. Pour a mixture of 1 part household bleach to 10 parts of water carefully on the area of the spill. Avoid splashing. The bleach and water solution should remain in contact with the spill area for at least 20 minutes.
5. Carefully wipe up the area with paper towels and avoiding dripping.
6. Double-bag all towels from the body fluids spill along with the gloves used to clean the mess and tie the bags closed.
7. Dispose of the double-bagged materials in red biohazard bags and place in the biohazard bins located in the closet marked with biohazard stickers and wash your hands thoroughly with soap and warm water.

Tips and Warnings

1. Many companies make bodily fluids spill kits that can be hung on the wall and contain all the needed supplies to clean up these spills quickly and easily.
2. All bodily fluid spills should be treated as potentially dangerous and need to be cleaned up immediately to ensure the safety of others.



Principles of Aseptic Technique

Purpose: To define the principles of aseptic technique:

1. Pathogenic organisms: those microorganisms that may cause infection or disease.
2. Sterile: free from microorganisms.
3. Asepsis: absence of infection by mechanical and chemical methods of cleanliness.
4. Aseptic technique: manner in which objects are kept sterile.
5. Sterilization: any process by means of which all bacterial, including spores, can be destroyed.
6. "Disinfection:" any process by means of which all, except the spore-bearing pathogenic organisms, are destroyed.
7. Surgically clean: mechanically cleansed but not sterile.
8. Antiseptics: chemical substances, which inhibit the growth and multiplication of bacteria without necessarily destroying them.
9. Deodorants: substances, which neutralize disagreeable odors.

I. Principles of Aseptic Technique:

A. Skin cannot be sterilized, therefore:

1. Patient's skin over operative area is thoroughly scrubbed in surgery or just prior to surgery.
2. All operators scrub their hands and arms thoroughly before sterile gowning and gloving.
3. Nurses and doctors gown and glove without touching outside of gown and gloves with skin.
4. If a glove gets a hole in it during an operation, it is to be changed at once.

B. Persons who sterile touch only sterile articles; persons who are not sterile touch only unsterile articles.

C. Non-sterile persons should avoid reaching over a sterile field. Sterile persons should avoid leaning over an unsterile field.

D. If in doubt as to sterility, consider an article not sterile. Examples may be:

1. If uncertain about actual timing of a sterilizer.
2. If a non-sterile person brushed close to a sterile table and vice versa.
3. If an autoclave tape looks as if the color has not been changed or if the control has not melted.
4. Any sterile package dropped on the floor is contaminated.
5. Re-autoclave all sterile equipment when questionable contamination has occurred.

E. Although entire gown was sterilized, consider a person sterile only from waist to axilla level, and only in front.

1. Tables are sterile only at table level.
2. Things dropped below waist level are considered contaminated.



3. Sterile persons should keep hands always in sight and above waist level.
 4. Do not fold arms when sterile as armpits may be damp from perspiration.
 5. Always face sterile areas. In passing other persons, use back-to-back, front-to-front technique.
 6. Sterile person is to keep contact with sterile areas to a minimum. Do not lean elbows on table. Stand back a few inches and work on table with hands.
 7. Sterile person is to keep work at a non-sterile field to a minimum:
 - a. In gloving, pick up sterile glove and step away from the table to pull it on.
 - b. Pick up total contents of package rather than one article to a time.
- F. Consider edges (table cover, wrappers, etc.) as unsterile.
1. Avoid touching edges of a wrapper when lifting contents from packages. Lift all contents by reaching down and lifting them up straight.
 2. If linen falls over side of table, discard it.
 3. If suture falls over the side of the table, cut it off at the table height or discard it.
- G. Wet areas are considered contaminated.
1. If a solution soaks through a sterile area to an unsterile area, the sterile area becomes contaminated when this is done.
 2. Be careful to lay sterile packages on dry areas.
 3. Cover a damp area on a sterile table with a thick sterile towel.
 4. Put Vaseline and lubricating jelly on a sponge on sterile table. Place wet ampoules, instruments, needles, etc. on double thickness or in sterile basin.
 5. In checking rooms, dry shelf well after damp dusting before replacing sterile packages.
- H. Keep air contamination at minimum.
1. Mask worn over nose as well as mouth.
 2. Keep all main corridor doors closed as much as possible.
- I. Sterile persons must keep within their sterile field and allow a wide margin of safety when passing unsterile areas.
1. Scrub nurse stands back away from operating table when drapes are being applied.
 2. Ask an unsterile person to step aside rather than trying to squeeze past them.
- J. Articles must be submerged when soaking. A floating article does not become sterile. If necessary, put a piece of gauze over the article so that it stays damp.
- K. Wrapping sterile packages.
1. Article to be completely covered and corners of the wrapper turned inside the wrapper.
 2. Leave a small cuff or underfold of wrapper so that the package may be opened without contaminating any part of it.



- L. A foolproof method of distinction between sterile and unsterile articles must be used.
 - 1. Sterile articles or equipment must be labeled, dated and kept within their own area.
 - 2. Unsterile articles and supplies must be clearly labeled and kept within their own area.
- M. In gloving, use skin to skin, outside of glove to outside of glove technique.
- N. In draping, the gloved hand should be on top of the drape and protected by a cuff of the drape.
- O. Grossly contaminated operative areas include:
 - 1. Any infected tissue.
 - 2. Purulent material or fluid.
 - 3. Gas gangrene or active pulmonary tuberculosis.
- P. Sterile tables are first considered contaminated to a case when the patient first enters the rooms.

II. What to do about contamination:

- A. Stop what you are doing and step away from the sterile field. Remove contaminated instruments if they are cause of contamination as with a needle stick.
- B. Discard contaminated articles.
- C. Request a new gown, gloves, drape, etc.
- D. Regown, reglove, or redrape. If glove contaminated let unsterile person remove the gloves so that you do not contaminate the other glove.

III. Instruments:

- A. Check instruments and supplies for each case, especially if someone else has picked them. If you are circulating, you are responsible for having all the necessary equipment. Checking in advance avoids unnecessary trips out of the room.
- B. Check preference cards and update frequently.
- C. Be careful with sharps (scissors, etc.) and do not put heavy instruments on smaller and more delicate instruments.
- D. Scrub nurses are to be sure that doctors' special instruments are cleaned, counted, and returned to the doctor.
- E. No scrubbed personnel are to leave the room during surgery except to obtain instruments from the autoclave.

Sunset Surgery Center TB Skin Test Policy

It is the policy of SSC to identify those healthcare workers with latent TB (LTBI) or active TB. Importantly, TST helps identify those who require preventative therapy to prevent latent infection from progressing to clinically active TB.

For practical purposes, the Mantoux PPD skin test is used.

Administer the Mantoux skin test, intradermally, injecting 0.1 ml of 5TU purified protein derivative (PPD) tuberculin on the inner forearm. Two PPD preparations are currently available in the US: Tubersol (Pasteur Merieux-Connaught) and Aplisol (Parkdale Pharmaceuticals). Administer the tuberculin syringe with the bevel facing up.

Test all healthcare workers in your facility that could be exposed to a patient with symptoms of TB. Include all employees who have patient contact, including paid and unpaid persons, part-time personnel, volunteer workers, maintenance and clerical staff, as well as temporary or contract workers. Exclude only those employees in your practice who have never had patient contact, such as certain billing staff.

Recommendations for Tuberculin Skin Testing (TST) for Healthcare Workers

	Low Risk	Medium Risk	Potential Ongoing transmission
Baseline TST	Yes, 2-step (PPD skin test) upon hire	Yes, 2-step (PPD skin test) upon hire	Yes, 2-step (PPD skin test) upon hire
Ongoing serial/screening TST	No	Every 12 months	Administer one TST (2-step PPD skin test) as soon as possible after exposure to <i>M. tuberculosis</i> . If negative, re-test 8-10 weeks after exposure.

Baseline Employee TST: The Two-step PPD Skin Test

It is the policy of SSC to provide an initial baseline two-step PPD skin test to every healthcare worker that has patient contact, at no charge to the employee.

The two-step method differentiates boosted reactions for reactions due to new infections. Two-step testing also reduces the likelihood that a LTBI is misinterpreted as a new infection. For some people who are infected with *M. tuberculosis*, delayed-type hypersensitivity to tuberculin may wane over the years. When tested many years later, they may have a negative skin test. However, this initial skin test may boost their ability to react to tuberculin, causing a positive reaction to subsequent PPD tests. This boosted reaction may be misinterpreted as a new infection.

To prevent this misinterpretation, perform two-step PPD testing on all newly employed healthcare workers who have *not* had a documented negative PPD test result during the previous 12 months. Perform a second test within 1-3 weeks after the first test. If the second test result is positive, this is most likely a boosted reaction and the healthcare worker should be classified as previously infected. If the second test result remains negative, classify the healthcare worker as uninfected; a positive reaction on a subsequent PPD test is likely to represent a new infection with *M. tuberculosis*.

Two-step TST Interpretation

- If the first test is positive, consider the person infected.
- If the first test is negative, test again one to three weeks later.
- If the second test is positive, consider person infected (boosted reaction).
- If the second test is negative, consider person uninfected.

Interpreting the TST

After 48 to 72 hours, measure the diameter of induration (palpable swelling). A negative test should produce a discrete, pale elevation (a wheal) 6 mm to 10 mm in diameter in most individuals, and a wheal of 0 mm to 5 mm in high-risk individuals.

A positive test is:

- ≥ 5 mm for very high-risk groups (HIV, persons with recent contact with an infected individual, injecting drug users whose HIV status is unknown, etc.).
- ≥ 10 mm for other high-risk groups (foreign born persons from high-risk areas, healthcare workers who serve high-risk groups, medically underserved, low-income populations including ethnic minorities such as blacks, Hispanics, and Native Americans, residents of long-term institutions, persons with conditions that increase the risk of TB (silicosis, more than 10% below body weight, chronic renal failure, diabetes mellitus, high dose corticosteroid and immunosuppressive therapy, some leukemias and lymphomas, and some other malignancies).
- ≥ 15 mm for those with no risk factors for TB.

False Positive/False Negative TB Tests

False Positive Results

Some causes of false positive TB skin test results are:

- A boosted reaction in an adult from childhood exposure to TB.
- Infection with other non-tuberculous mycobacteria.
- Previous vaccination with BCG. (i.e., BCG, or bacilli Calmette-Guerin, is a TB vaccine used in many countries with a high prevalence of TB. BCG is generally not used in the U.S.)

False Negative Results

Anergy can sometimes cause false negative TB skin test results. Consider anergy in persons with no reaction and those:

- With HIV (33%) and AIDS (60%).
- With overwhelming miliary or pulmonary TB.

- Who have severe or febrile illness.
- Who have measles or other viral infections.
- With Hodgkin's disease or sarcoidosis.

Detect anergy by administering at least two other delayed-type hypersensitivity antigens, such as tetanus toxoid, mumps, or Candida, by the Mantoux technique, in conjunction with TB skin testing.

Those with reactions of ≥ 3 mm to any antigens, including PPD, are NOT anergic. Record results as mm of induration, not positive or negative. If anergy testing is less than 3 mm, patient is anergic. Assess the probability of infection. If risk is high (known contact of persons with TB or persons from a group of high prevalence of TB), evaluate for preventive therapy.

Periodic Retesting of Employees

Based on risk assessment: If your facilities falls into the medium risk category, provide TB skin testing to all employees annually.

Based on exposure to a person with TB: If there is employee exposure to an individual with infectious TB, repeat skin testing as soon as possible after the exposure and if that TST is negative, perform another TST 8-10 weeks afterwards. It takes 2 to 10 weeks from the time of infection for an exposed person to react to the skin test.

Do not repeat TSTs annually or after an exposure for employees with positive skin test. For those employees, it's necessary to rely on chest x-rays and symptoms to see if they have tuberculosis. Require them to get a chest x-ray if they have a cough lasting for 3 weeks and 2 or more TB symptoms. Routine yearly chest x-rays are not necessary.

TUBERCULOSIS TEST FORM

I hereby request that I be given a PPD test through the Practice in order to meet the state public health requirements of a screening test for tuberculosis. I understand that the Practice assumes no liability for this test and that if I have a positive reaction, I will consult my primary care physician.

Date: _____

(Employee's signature)

(Employee's printed name)

Date of birth: _____

Department: _____

Date test given: _____ Date test read: _____

Read by: _____

Results: _____ Negative _____ Positive Arm: _____ Left _____ Right

Lot #:



Sunset Surgery Center

HEPATITIS B VACCINATION FACT SHEET

WHAT IS HBV?

Hepatitis B virus (HBV) is a potentially life-threatening bloodborne pathogen. It causes hepatitis, an inflammation of the liver and although most people with hepatitis B recover completely, approximately 6-10% become chronic carriers and 1-2% die. In the group of chronic carriers, many have no symptoms but can transmit the virus. Carriers also face a significantly higher risk for other liver ailments such as cirrhosis of the liver and liver cancer.

HBV infection is transmitted through exposure to blood and other infectious body fluids and tissues including semen, tears, saliva, urine, breast milk, and vaginal secretions. Health workers and students are at high risk of acquiring Hepatitis B because of frequent contact with blood and potentially contaminated body fluids. Approximately 8,700 health care workers each year contract Hepatitis B. Health care persons must use work practices and protective clothing and equipment to prevent exposure to potentially infectious materials. These procedures are described in the HCC Health Sciences Division Infection Control Policy. However, the best defense against hepatitis B is vaccination.

WHAT DOES VACCINATION INVOLVE?

The hepatitis B vaccination is a noninfectious, yeast-based vaccine given in three injections in the arm. It is prepared from recombinant yeast cultures, rather than human blood or plasma. Thus, there is no risk of contamination from other blood borne pathogens nor is there any chance of developing HBV from the vaccine.

The second injection should be given one month after the first, and the third injection six months after the initial dose. More than 90 percent of those vaccinated will develop immunity to the hepatitis B virus. To insure immunity, it is important for individuals to receive all three injections. At this point it is unclear how long the immunity lasts so booster shots may be required at some point in the future.

No serious side effects or allergic reactions have been reported during the course of clinical trials. A few persons experience tenderness and redness at the site of the injection. Low-grade fever may occur. Rash, nausea, diarrhea, joint pain, fatigue/weakness and headache have also been reported. Other more serious adverse reactions have occurred infrequently.

Each employee should receive counseling from a health care professional before making a decision about vaccination. This discussion should help the employee make an informed decision.

WHAT IF I DECLINE VACCINATION?

A person who initially declines to receive the vaccine, must sign and return the attached waiver. If the employee later chooses to take the vaccine, the verification must be submitted to the coordinator/director.

Sunset Surgery Center

Single Use Vial Policy

The transmission of bloodborne viruses and other microbial pathogens to patients during routine healthcare procedures continues to occur due to unsafe and improper injection, infusion, and medication vial practices being used by healthcare professionals within various clinical settings throughout the United States.

Breaches in safe injection, infusion and medication vial handling practices continue to result in unacceptable and devastating events for patients. More than 35 outbreaks of viral hepatitis have occurred in the United States in the past 10 years due to these unsafe practices and other breaches of infection prevention procedures. These outbreaks have resulted in the transmission of either hepatitis B or C to more than 500 patients. The unsafe practices that were used by physicians and/or nurses in these outbreaks can be categorized by:

- a) Syringe reuse between patients during parenteral medication administration to multiple patients
- b) Contamination of medication vials or intravenous (IV) bags by accessing them with a used syringe and/or needle
- c) Failure to follow basic injection safety practices when preparing and administering parenteral medications to multiple patients
- d) Inappropriate use of finger stick devices and glucometer equipment between patients

APIC strongly supports adherence to the following safe injection, infusion, and medication vial practices.

Aseptic Technique

- Perform hand hygiene prior to accessing supplies, handling vials and IV solutions, and preparing or administering medications.
- Use aseptic technique in all aspects of parenteral medication administration, medication vial use, injections, and glucose monitoring procedures.
- Store and prepare medications and supplies in a clean area on a clean surface.
- Never store needles and syringes unwrapped as sterility cannot be assured.
- Discard all opened vials, IV solutions, and prepared or opened syringes that were involved in an emergency situation.

IV Solutions

- Never use intravenous solution containers (e.g. bags or bottles) to obtain flush solutions, etc. for more than one patient.
- Never use infusion supplies such as needles, syringes, flush solutions, administration sets or intravenous fluids on more than one patient.

- Being/initiate administration of spiked IV solutions (IV bag entered by the spiking tube) within one hour of preparation. If administration is not begun within 1 hour of spiking the bag, the IV and tubing shall be promptly discarded.
- For unspiked IV solutions (not accessed by IV tubing spike) follow the pharmacy prepared or manufacturer prepared IV solution expiration date.
- Use a USP 797 pharmacy clean room (ISO 5) to prepare admixtures of IV solutions.
- Disinfect IV ports using friction and 70% alcohol, an iodophor or an approved antiseptic agent. Allow to dry prior to accessing.
- Always use single-dose containers for flush solutions .

Syringes

- Remove sterile needle/cannula and/or syringe from package just prior to use.
- Never use medication in a syringe for more than one patient even if the needle is changed between patients. Changing the needle but not the syringe is unacceptable.
- Utilize sharps safety devices whenever possible.
- Discard syringes, needles and cannulas after used directly on an individual patient or in their IV administration system.
- Dispose of used needles at the point of use in an approved sharps container.
- Do not prepare medication in one syringe to transfer to another syringe, i.e. nurse draws up solution into syringe then transfers the solution to a syringe with plunger removed or injected into the bevel of the syringe to then be injected into the patient.

Vials

- Always follow the manufacturer's instructions for storage and use.
- Use single-use or single-dose vials only.
- Always use a sterile syringe and needle/cannula when entering a vial. Never enter a vial with a syringe or needle/cannula that has been used on a patient.
- Cleanse the access diaphragm of vials using friction and 70% alcohol or other antiseptic. Allow to dry before inserting a device into the vial.
- Discard single-dose vials after use. Never use them again for another patient.
- Never store vials in clothing or pockets.
- Use filter needles to withdraw solution from an ampule.
- Never pool or combine leftover contents of vials for later use.
- Never leave a needle, cannula, or spike device inserted into a medication vial rubber stopper because it leaves the vial vulnerable to contamination.
- Inspect vials and discard if sterility has been, or is thought to be compromised. Examine the vial for any particular matter, discoloration or turbidity. If present, do not use and discard immediately. All vials used during an emergency should be discarded as sterility cannot be guaranteed.

Healthcare Workers

- Provide the hepatitis B vaccination series to all previously-unvaccinated healthcare personnel whose activities involve contact with blood or body fluids.
- Check and document post-vaccination titers one to two months after completion of the vaccination series.
- Report body fluid and needle-stick/sharps injuries immediately.
- Evaluate needle-stick/sharps injuries for preventability.
- Use safety devices for liquid injection syringes. Sharps (syringes/needles) with attached safety devices must be activated prior to disposal.
- Ensure staff preparing or administering injections or other parenteral medications are competent to aseptically perform these tasks.
- Periodically assess compliance with safe injection practices by observing and evaluating personnel performing these procedures.

Conclusion:

Use of safe injection practices is critical to prevent microbial contamination of products administered to patients. The ongoing reports in the United States of hepatitis B and C transmission to patients and outbreaks of bacterial infections associated with unsafe injection practices is an indication that diligence is needed to assure that these preventative practices are being scrupulously followed in all healthcare settings. Healthcare workers and their managers must understand, practice and promote safe injection, infusion and medication vial practices. Administrators of medical facilities must support safe injection practices and provide resources to ensure employees have the training and equipment to safely implement these procedures. The role of the Infection Preventionist is to assess procedures for safety, develop programs, train, and implement safe injection, infusion and medication vial practices so they are the absolute standard of care throughout the variety of healthcare settings that exist today. The health and safety of our patients require adherence to infection prevention practices by all healthcare workers. These infection prevention practices should prevent cross contamination, transmission, and outbreaks of infection due to unsafe injection, infusion and medication handling, and preparation and administration practices.



SAFE INJECTION PRACTICES and SINGLE and MULTI-DOSE VIALS:

In order to maintain compliance it is the policy of Sunset Surgery Center to adhere to the following rules and ensure all medications, vials and usage of liquid or solid medications be dispensed and administered in compliance with CDC guidelines.

1. **Single Use:** Single needle and single syringe are used for a single patient. Medications, regardless of single dose or multi dose, are always drawn up utilizing sterile technique into a new needle and new syringe.
2. **Intravenous Tubing:** New intravenous tubing and connectors shall be used for each patient.
3. **Intravenous Solution:** Bags of Intravenous solution are used per patient and are discarded in compliance with CDC regulations when the solution runs out or the IV is discontinued from the patient. No bag of intravenous solution shall be used on multi patients at any time.
4. **Single Dose Vials:** single dose vials are for single patient and single dose usage. These should be opened sterilely and administered in a single dose to a single patient. Any unused medication should be discarded.
5. **Multi-dose vials definition:** A multi-dose vial is a vial of liquid medication intended for injection or infusion that contains more than one dose of medication. Multi-dose vials are labeled as such by manufacturers. No vial shall be considered multi-dose unless labeled as such by the manufacturer.
6. **Usage of Multi-Dose Vials:** multi-dose vials should be dedicated to a single patient whenever possible. When a multi-dose vial is used for more than one dose or used for more than one patient, strict sterile policy must be used.
7. **Sterile technique for usage of Multi-Dose vials.** Strict sterile technique is always used when giving any medication. For multi-dose vials, the injection port must always be cleaned with alcohol prior to withdrawal of the medication. Always a completely new sterile syringe and sterile needle must be used to draw up the medication. For each dosage withdrawn, a completely new syringe and completely new needle must be used. For example, it is not appropriate to withdraw medication inject into a patient and then withdraw from the bottle again with the same syringe, even if the needle is changed. To withdraw from the multi-dose vial, always a completely empty and new sterile syringe must be used with a completely new and sterile needle.
8. **Pre-Drawn Medications:** Medications pre-drawn at the beginning of the day must be specially labelled with the time drawn, initials of the individual drawing up the medication, name of the medication, strength of the medication and expiration date of the medication.
9. **Manufactured Pre-filled medications:** Regardless of the amount of medication present in the pre-filled syringe, they must only be used on one patient and discarded.



10. **All medications must be discarded according to expiration date.** The only exception to this is if a lifesaving medication is on back order or not readily available. All attempts must be made to replace any expired medication in a timely fashion.
11. **Opened multi-dose vials:** if a multi-dose vial has been opened or accessed, the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for the opened vial.
12. **Multi-dose vials should not be mixed:** multi-dose vial should not be mixed with other multi-dose vials unless directly specified by the manufacturer.
13. **Injections are to be given only by trained personnel:** all injections are to be given only under the direction of a physician by trained personnel. Personnel must have a valid state license to give injections and/or be under the direct supervision of the physician. All laws regarding the administration of medications are to be followed strictly.
14. **Sterility must be maintained.** Whenever sterility is compromised or questionable the vial must be discarded.
15. **Disposal of sharps:** All sharps are disposed of in a puncture resistant sharps container. Sharps containers should be replaced when the fill-line is reached or when the container is 2/3 full.
16. **Point-of-care devices, e.g. blood glucose monitoring devices or machines.** Point of care devices need to be cleaned with an EPA registered disinfectant/germicidal wipe.



Continuity and Excellence of Care Policy

(Physical Examination and Pre-surgical Evaluation, Intraoperative, and Postoperative Policy)

Policy: To ensure that each patient of the center is under the proper care of a physician, each patient admitted to the center receives a:

1. Physical Examination, which must include a medical history of the patient, within the 30 days immediately preceding the date of the patient's surgery
2. Pre-surgical Evaluation conducted by a physician on the day of the patient's surgery or within the 7 days immediately preceding the date of the patient's surgery
3. Consent forms should be completed on the day of the patient's surgery or within the 7 days immediately preceding the date of the patient's surgery
4. Any clinical observations of the patient, such as the notes of the physician, a nurse, or any professional person in attendance
5. Reports of all studies ordered, including laboratory and radiological examinations
6. Confirmation of the original diagnosis, or diagnosis at the time of discharge
7. A report of any surgery performed by the surgeon on the patient, prepared by the operating surgeon.
8. A description of the procedure followed in any administration of anesthesia to the patient
9. A recovery report for the patient
10. A summary of discharge, including without limitations, the disposition of the patient and any recommendations and instructions given to the patient
11. Documentation that a member of the nursing staff interviewed the patient 72 hours after the patient was discharged from the center to determine the condition of the patient and whether or not the patient was satisfied with the services provided, and to receive any complaints of problems the patient may have



Admission Criteria/Patient Selection

Purpose: To provide the highest quality of healthcare to patients, while ensuring their safety. It shall be the responsibility of the physician to correctly evaluate the patient and the procedure preoperatively for suitability for outpatient surgery

Policy: In order for Sunset Surgery Center to deliver the highest quality of care, our services will be provided according to the highest standards of professional practice through adherence to the following:

1. Medical Clearance

- a. If applicable, medical clearance should be recorded. A current history and physical examination by the surgeon, anesthesia provider, or the patient's personal physician is recorded within thirty (30) days of surgery on all patients for major surgery, and for those patients for minor surgery who require a physical exam. The medical record must contain a current medical history taken on the same day as the surgical procedure, and recorded by the surgeon or anesthesia provider prior to the admission of anesthesia.
- b. Not more than 30 days before the date of scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician, or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice and ASC policy.
- c. The center will ensure that each patient has the appropriate pre-surgical and post-surgical assessments completed and all the elements of the discharge requirements are completed.
 - i. The patient can tolerate a surgical experience;
 - ii. The patient's anesthesia risk and recovery are properly evaluated
 - iii. The patient's post-operative recovery is adequately evaluated;
 - iv. The patient received effective discharge planning; and
 - v. The patient is successfully discharged from the ASC
- d. The purpose of the comprehensive medical history and physical assessment is to determine whether there is anything in the patient's overall condition that would affect the planned surgery, such as a medication allergy, or a new or existing co-morbid condition that requires additional interventions to reduce risk to the patient, or which may even indicate that an ASC setting might not be the appropriate setting for the patient's surgery. The H & P must be comprehensive in order to allow assessment of the patient's readiness for surgery and is required regardless of the type of surgical procedure. The H & P should specifically indicate that the patient is cleared for surgery in an ambulatory setting.
- e. It is a requirement of the facility that the H & P be completed and documented for each ASC patient no more than 30 calendar days prior to date the patient is scheduled for surgery in the ASC.
- f. In cases where the patient is scheduled for two surgeries in the ASC within a short period of time, the H & P may be used so long as it is completed no more than 30 calendar days before each surgery.



- g. Other qualified licensed individuals are those licensed practitioners who are authorized in accordance with their State scope of practice laws or regulations to perform an H & P and who are also formally authorized by the ASC to conduct an H & P. Other qualified licensed practitioners could include nurse practitioners and physician assistants.

2. Admission and Pre-Surgical Assessment

- a. Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy that includes an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals.
- b. In accordance with requirement 416.42 (a) (1), the physician will examine the patient immediately before surgery to evaluate the risk of the anesthesia and of the procedure for that patient. The patient must be assessed for any changes in his/her condition since the patient's H & P was performed that might be significant for the planned surgery. Any changes in health and medication can have an impact on the patient's ability to tolerate the surgery or anesthesia, and the post-admission pre-surgical assessment is designed to identify these changes and take appropriate action, up to and including postponing or cancellation of the surgery. Further, if the practitioner finds that the H & P done before admission is incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the H & P, examining the patient, and completing the update may disregard the existing H & P, and conduct and document in the medical record a new H & P prior to the surgery.
- c. If upon examination, the licensed practitioner finds no change in the patient's condition since the H & P was completed, he/she may indicate in the patient's medical record that the H & P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H & P was completed. Likewise, any changes in the patient's condition must be documented by the practitioner in the update note prior to the start of surgery.
- d. The comprehensive H & P must be submitted to the ASC prior to the patient's scheduled surgery date, in order to allow sufficient time for review of the H & P by the ASC's medical staff and adjustments if necessary. At a minimum, the H & P must be placed in the patient's medical record prior to the pre-surgical assessment required under 416.52 (a) (2), since that assessment must first consider the findings of the H & P before examining the patient for changes. Both the H & P and the pre-surgical assessment must be placed in the patient's medical record before the surgery.



3. The following conditions do not warrant admission to the facility:

- a. Cases where compromise of the airways is expected
- b. Cases where considerable blood loss is expected
- c. Cases where considerable postoperative pain is expected
- d. Cases where the patient is not ASA I or ASA II
 - i. ASA-I patients are those without any organic, physiologic, biochemical, or metabolic disturbance.
 - ii. ASA-II patients are those with a systemic disturbance which may be of a mild to moderate degree but which is either controlled or has not changed in its severity for some time.
- e. ASA III patients may be done at the discretion of the anesthesiologist
 - i. ASA-III patients may be operated upon in Plastic Surgery Institute on a case-by-case basis, determined by the medical director and the anesthesiologist
- f. Cases where anesthesia is expected to be prolonged; i.e. over 6 hours



Patient Identification Policy

Policy: Valid Identification will be checked for every procedure performed at Sunset Surgery Center.

Procedure:

1. When a patient signs in to Sunset Surgery Center for procedures, they will be asked for their valid picture ID
2. The valid Picture ID will be scanned into the system. If for some reason the patient refuses to present a valid picture ID, their social security number is to be used as another identifying marker.
3. Arm bands are required for both the patient and their partner when performing IVF procedures.
4. The name and date of birth indicated on the valid photo ID will be compared against the arm band. If there is a discrepancy, the supervisor is to be notified immediately, and the check in process is to be stopped until a resolution has been found.
5. The ID number and expiration date will be entered into the computer to document that valid identification was checked.
6. The receptionist will place the arm band on the patient having the procedure. For IVF procedures, the receptionist will place an arm band on the patient's partner and send this patient to the RRFC for sample collection.
7. Once completed, the supervisor shall be notified to begin the consent signing process.



Discharge of a Patient

Purpose: To set guidelines to establish criteria for discharging a patient that has been determined to have fully recovered from anesthesia. To ensure a safe transition of the post anesthesia patient in an outpatient setting.

Policy/Procedure:

1. Minimum Requirements – Length of Stay

- a. Patients undergoing general anesthesia will be monitored in the PACU area until criteria has been met. Minimum length of stay 30 minutes.
- b. Patients must remain in PACU for a minimum of 15 minutes after IV narcotics have been administered.

2. Discharge Criteria

- a. A numeric score of at least eight (8) using the Aldrete Evaluation Scale must be met prior to discharge.
- b. A numeric score of less than eight (8) on the Aldrete Evaluation scale will be observed until a proper discharge score can be reached.
- c. Patient's temperature must be greater than 96F to be discharged.
- d. A numeric score of less than five (5) without any improvements over time warrants the patient to be transferred to outside facility for further monitoring or treatment.

3. Physician Available

- a. Because anesthesia is administered, a physician is immediately available until the patient is discharged from the PACU.

4. Post-Surgical

- a. The patient's post-surgical condition will be assessed and documented in the medical record by a physician, other qualified practitioner, or a registered nurse with a minimum, post-operative care experience in accordance with applicable State health and safety laws, standards of practice and ASC policy.
- b. Patient will be given adequate written post-operative instructions to include the procedures to follow if complications or emergency situations occurs. The instructions will be given to an adult who is responsible for the patient's care and transportation.
- c. Follow-up appointments will be made at time of discharge and overnight supplies given if applicable.

5. Discharge – from Center

- a. Patients must be discharged in the company of a responsible adult.
- b. Center personnel will assist with discharge from the recovery area; every patient is discharged by wheel chair.
- c. For any patient receiving anesthesia in the Center, the staff ensures that the patient is transported in a vehicle with a responsible adult.
- d. Patients receiving local anesthesia can transport themselves.



6. Documentation

- a. At discharge, the following will be documented: ambulatory status, instructions given with copy for the chart and patient, any postop meds or prescriptions given, IV/HL removed, post-op appointment made, discharge to care of responsible adult, and discharge nurse's signature.
- b. Each patient is provided a discharge order signed by the physician who performed the surgery or procedure. The discharge instruction sheet will be reviewed with the patient and the responsible adult who transports the patient home.
- c. Documentation will be completed in the patient's chart.



Handling the Unruly Patient or Significant Other

Purpose:

Sunset Surgery Center would like to handle unruly patients and/or significant others in the most humane manner possible while maintaining a level of decorum in the Center that makes patients, significant others, and staff comfortable.

Policy: Should a patient/significant other become disruptive for any reason, staff are to act immediately and without hesitation. As there are different areas where patients may be in the office, different procedures must be undertaken to manage each situation.

Procedure:

1. Don't respond in kind to the patient (don't fight fire with fire). BE CALM.
2. GET HELP. While you don't want to "gang up" on the individual, you don't want to try to resolve the situation without help, or at least, without a witness.
3. Convince the patient to move to a pre-designated area where there is no contact (or at least reduced contact) with other patients/significant others.
4. Listen to the patient's demands, requests, and desires. Most people get upset when they believe they are being misunderstood or their needs are not being responded to.
5. Find the manager of the area where the disruption occurred (Business Manager for the waiting area, Clinic Director for the exam area, Operating Room supervisor for the OR area) and a physician
6. If you are concerned regarding anyone's physical safety, call 911

The designated areas for patient amelioration are as follows

:

If the person is in the	WAITING AREA	direct them to the SURGERY SCHEDULERS
If the person is in the	PRE-OP/PACU	direct them to the OFFICE
If the person is in the	OPERATING ROOM	KEEP THEM IN THE OR



Emergency Return of Patient to Operating Room

Purpose: To ensure patient safety at all times.

Procedure:

If the patient has been discharged from Sunset Surgery's Care

- Patient is instructed to report to the nearest Emergency Department and the Surgeon is notified immediately.
- Anesthesia must be alerted immediately to provide emergency cover.
- If possible patient and partner or accompanying adult must be informed of the need and purpose for the return to the operating room.
- In an emergency situation the patient should be moved to the operating room and all monitoring equipment set up. Any medication likely to be required by the anesthesiologist should be available.
- An RN or MD should monitor the patient until the anesthesiologist arrives.
- Surgical prep and draping can take place before anesthesiologist arrives.
- It is as the surgeon's discretion whether or not to move patient to the operating room before the arrival of the anesthesiologist.

If the patient is under Sunset Surgery's Care Post Operatively and the notification is received that a patient needs to return to the Operating Room after a procedure, the following steps are to be followed:

- Notify the Surgeon immediately.
- The Surgeon/Physician notifies the Surgery Scheduler and instructs her about the time the patient needs to return to the Operating Room.
- The Surgery Scheduler then notifies the following personnel:
 - Anesthesiologist
 - Certified Surgical Technician
 - Registered Nurse
 - Surgery Center Administrator



Transfer of a Patient to the Hospital

Purpose: To ensure that a patient can be transferred safely and efficiently to the nearest E.R. with least amount of trauma and risk to patient. The following problems fit the criteria for transfer to a hospital:

1. Preoperative complications
2. Patients needing postop IM or IV pain control
3. Patients with intra-operative complications
4. Patients with post-operative complications
5. Patients with an exacerbation of a comorbidity such as uncontrolled diabetic reaction or hypertension

Policy: The need to transfer a patient will be decided by an M.D. The M.D. must state Routine, Urgent or Emergency transfer.

1. For routine transfers:
 - a. Notify the emergency department at Southern Hills Hospital: (702) 880-2800.
 - b. After the physician has discussed the patient's transfer with the family, the office staff will maintain communication with family members to alleviate anxiety.
 - c. Notify the ER that the patient is ready for transport and give a brief report to the nurse or physician including but not limited to:
 - i. Doctor's name
 - ii. Patient's name and DOB
 - iii. Diagnosis
 - iv. Vitals
 - d. Ambulance service will be notified to transport the patient to the hospital.
 - e. For Quality Assurance purposes, the pre/postop nurse makes a follow-up telephone call within 24 hours to evaluate patient's progress or the patient will be visited at the hospital by a staff member or physician on staff.
2. For Urgent transfers, which require transfer of the patient within 30 minutes to the ER:
 - a. Call Ambulatory Service:
 - b. Give all information requested.
 - c. Do not hang up until instructed to do so.
 - d. Call Southern Hills Hospital: (702) 880-2800
 - e. Give Doctor's name
 - f. Give patient's name
 - g. Give patient's DOB
 - h. Give diagnosis
 - i. Patient fit for interview or not?
 - j. Insurance information.
3. **For emergency transfers which require the immediate transfer of the patient to the ER:**
 - a. Call 911 for immediate transfer and give all information that is requested. Do not hang up until instructed to do so
 - b. Call Southern Hills Hospital: (702) 880-2800
 - i. Give Doctor's name



- ii. Give patient's name and DOB
 - iii. Give diagnosis
 - iv. Give vitals (is OR required?)
 - c. Provide appropriate medical care (according to BLS/ACLS protocol) until emergency personnel arrive.
 - d. Provide assistance to emergency personnel as needed.
 - e. Maintain communication with family members.
 - f. For Quality Assurance purposes, the pre/post-op nurse or physician makes a follow-up telephone call within 24 hours to evaluate patient's progress or visit the patient in the hospital.
4. The nurse responsible for the patient needing transfer will fill out an incident report.



Unexpected Blood Loss Policy

Policy: In the event of an unexpected blood loss great enough to cause hypotension lower than 80/60 combined with a tachycardia whose rate is greater than 120, it is the responsibility of the anesthesiologist or nurse anesthetist to notify the surgeon if the operative procedure is still taking place. If the patient were to develop hypotension/tachycardia in the recovery room, it is the responsibility of the recovery room nurse to notify the surgeon and anesthesiologist or nurse anesthetist.

If it is felt that a significant blood loss may have occurred, procedures will begin to transfer the patient immediately to Southern Hills Hospital. (See Emergency Transfer Procedure.)



Incident Report Policy

POLICY:

Documentation of all unusual incidents in the Center will be made for future reference by completion of an appropriate Incident Report Form.

INCIDENTS (defined):

All incidents that are considered controversial or unusual in nature.

1. Major complaints of any nature made by a patient or visitor.
2. Loss of personal belongings.
3. Accidents occurring in the Center.
4. Incorrect administration of drugs.
5. Serious reactions.

PROCEDURE:

1. Complete a patient incident report with all pertinent information, i.e.:
 - a. All accidents
 - b. Incorrect drug administration
2. Completed incident report will be given to the Director of Nursing.



Malignant Hyperthermia (M.H.) Protocol

Prepared By: The Malignant Hyperthermia Association of the United States (MHAUS)

Policy: To maintain a cart stocked with all drugs and supplies needed during a malignant hyperthermia crisis. This may be included with the other emergency supplies. In addition, every patient shall be screened for a personal or family history of malignant hyperthermia. In the event a patient develops Malignant Hyperthermia it is policy that the staff of Sunset Surgery Center follow the Malignant Hyperthermia algorithm and manual along with the clearly labeled kit that is located in OR 1 next to anesthesia machine.

Purpose: To assure patient care and to minimize confusion during a malignant hyperthermia crisis.

Procedure:

Malignant Hyperthermia Cart:

1. M.H. supplies should be checked after each use and routinely every six months.
2. The refrigerator temperature should be checked regularly.
3. Drugs and fluids on the cart are to be checked for expiration dates and replaced immediately, if outdated.

Drugs and Equipment for Treatment of M.H.:

1. Ensure that the following are available for immediate use in the OR suite:
 - a. ECG monitor
 - b. Pulse oximeter, electronic temperature measuring device with appropriate probes for monitoring central temperature (e.g. nasal, rectal, axillary, (esophageal).
 - c. Capnograph
 - d. A bag of ice will be kept in the refrigerator
2. Drugs in M.H. cart:
 - a. Dantrolene sodium IV – 18 vials*
 - b. 3,000 ml sterile water for injection USP (without a bacteriostatic agent to reconstitute Dantrolene.
 - c. 50 cc vials sodium bicarbonate 8.4% x 3
 - d. Amiodarone x 3
 - e. 50% glucose 50 ml x 2
 - f. Regular insulin 100 units/ml x 1 (refrigerated)
 - g. 10% calcium chloride x 2

** An additional 18 vials are available with Dr. Andrew Cash at West Sunset Surgery Center



Cooling Equipment:

1. 60 ml syringe x 5
2. 60CC Toomey syringe x 2
3. 16F Nasogastric tube x 2
3. Ice Packs

Equipment:

1. IV supplies
 - 16G x 4
 - 18G x 4
 - 20G x 4
 - 22G x 4
 - 24G x 4
 - IV Tubing x 2
2. Tympanic Membrane Thermometer x 1
- 3.. Dynaesthetics Vapor Clean Charcoal Filters X 4

Training

1. An annual in service will be conducted to train and re-educate staff on what to do in a malignant hyperthermia crisis. A mock drill will be conducted at the conclusion of the in service.

Clinical Management/Procedure:

- Use Emergency Alarm System (800#). All available nurses and doctors must report.
- Call 911
- Call West Sunset Surgery and instruct them to bring the other 18 vials of Dantrolene immediately.
- Note time of diagnosed malignant hyperthermia.
- Stop all inhalational anesthetics.
- Hyperventilate with 100% oxygen.
- Obtain crash cart (located in recovery) and MH box (located in OR 2)
- Start mixing Dantrium with 60 ml sterile water for injection per vial. Two nurses should be allocated to this task.
- Obtain fluids and ice.
 - IV n/saline 1000 ml—in fridge in OR
 - NaCl for irrigation 500 cc—also in fridge in OR
 - Bags of ice—in freezer in staff lounge
- One RN must keep written record of all medications and procedures.
- Start cooling with bags of ice in axilla, groin, and as much body surface as possible.



- Lavage stomach, bladder, rectum if possible—have nasogastric tube available with 60 ml Toomey syringe.
- Change anesthesia circuit and bag. Disconnect vaporizers from fresh gas circuit.
- Have available blood sample tubes
 - Red top
 - Lavender
 - Blue
 - Green
- Have sodium bicarbonate ready
- When temperature stabilized, transfer to hospital with anesthesiologist and RN in attendance.



Medication Policy

Policy: In order to maintain compliance with all state, federal, regulatory and accrediting Agencies, Sunset Surgery Center shall adhere to the following:

- IV fluids such as Lactated Ringers and normal saline, tubing needles will be readily available in the facility as a single use supply
- Emergency medications are located and readily available in the locked crash cart located in the nursing station, PACU, as well as in the locked anesthesia carts in each operating room.
- Any medications that need to be refrigerated must be stored in a locked refrigerator. Food must not be stored in this refrigerator except if the food is used as a vehicle for the administration of drugs.
- All narcotic drugs must be logged into and checked out of stock only by a licensed health care professional. The dated narcotic logbook, which includes the use of narcotics on individual patients, is kept in the locked narcotic cabinet in the nurse's station. This logbook has sequentially numbered pages in a bound journal.
- The Director of Nursing will oversee the control of dangerous drugs and controlled substances. Controlled substances are stored in a double locked narcotics cabinet which is fastened to the wall which is located in the nurse's station. The narcotic inventory is verified by two licensed members of the surgery center at least weekly and on every day that narcotics are used.
- All drugs must be prescribed by a physician and administered by a physician or a Registered Nurse.
- All drugs are checked monthly for expiration. All drugs that are expired are disposed of properly and recorded in the "discard log" located in the narcotics cabinet. Any narcotics that are to be wasted are logged and signed by two licensed health care providers.
- If medication or treatment orders are given verbally by qualified physicians to the RN, the RN will get signed written orders by the end of the business day. If the doctor calls the order in on the phone, the order will be written, and read it back to verify the order. When the RN charts it, the RN writes (TO) to signify this is a telephone order.
- The RN prepares any medication using aseptic technique at the nurse's station. The medication syringe will be labeled with the patient's name, medication, dosage, the date and time prepared, by whom the medication was prepared, and the expiration date and time of the medication that was drawn. Whoever prepares the medications will be the same person giving the medications. The patient ID armband will be checked and verified before administering any medications.
- All IV insertion and monitoring will be done by a trained and licensed Registered Nurse.



- Whenever an adverse effect of medication occurs that the medication infusion be immediately stopped and the physician notified. The RN will stay with the patient, monitor the patient and treat any symptoms until the physician arrives.
- All medications will be prepared and administered in a safe and effective manner in accordance with the program of infections and communicable diseases and in accordance with manufacturer's instructions. It is the policy of SSC that all medication vials are single use only.
- A copy of the current ACLS algorithm is kept with the AED on the code cart located in the PACU station. The following medication must be kept within the crash cart as required by ACLS algorithm:
 - Epinephrine
 - Plain lidocaine
 - Vasopressors other than epinephrine, such as neosynephrine and ephedrine
 - Narcotic antagonists such as narcan
 - Seizure arresting medication such as Dilantin or Valium
 - Bronchospasm arresting medications such as albuterol or aminophylline
 - IV corticosteroids such as dexamethasone
 - Antihistamines
 - Anti-hypertensives
 - Non-depolarizing muscle relaxants such as rocuronium or vecuronium
 - Benzodiazepine revering agent such as flumazenil
 - Atropine



Medication/ Product Recall

Purpose: To establish procedures which are to be implemented **immediately** upon receipt of a notice of a medication or medical device alert or notification from a manufacturer or the Food and Drug Administration (FDA) issuing a caution or recall of a product.

Principles:

1. Products affected by a FDA or manufacturer's recall should **not** be used for patients and should be discarded or sent back to the company upon request and in accordance with instruction from the issuing agency.
2. All recalled products should be collected immediately and taken to the Office Manager.
3. Defective products/medication used on patients prior to recall notification must be tracked and findings documented.
4. Manufacturers are responsible for products affected by a recall.

Procedure: Receipt of all recall notices by the FDA, Manufacturers, distributors or other vendors shall be handled by the Director of Nursing. Upon receipt, the Director of Nursing will:

1. Verify that the particular item is stocked in the center.
2. If stocked:
 - a. Alert all personnel.
 - b. Issue instructions to collect all recalled products.
 - c. Assist with the collection.
 - d. Record all recalled products collected, including numbers of each, and initial and date documentation to include all staff involved.
 - e. If instructions for return or destruction are provided in the recall notice, they shall be followed.
 - g. Investigate situations where the product had been utilized by patients prior to the recall
 - h. If possible, trace the disposition of potential stock that may have been used under recall and notify the physician to address patient safety concerns.
3. If not stocked:
 - a. It will be noted that the product was not in inventory.
4. If the recalled product is a medication:
 - a. Record it on the Medication Supply Inventory Record that the product was returned, due to a product recall.
 - b. Fill out the Product Return form to accompany the package, and make a copy for our records.
 - c. Return the medication to the appropriate company and locatio



- d. If the medication to be returned is a controlled substance, **two** staff members **must package and seal** the delivery device. This will be recorded on the narcotic count sheet as "returned for product recall." It will be documented on the Medication Supply Inventory Record and a **Narcotic Return Form** will accompany the package.



Personal Protective Equipment Policy

Purpose: To ensure the employee is protected from possible contamination with potentially hazardous materials. To comply with OSHA recommendations for dealing with blood borne pathogens. PPE includes:

- Disposable, impervious gloves
- Gloves
- Shoe covers
- Masks
- Goggles
- Mask with eye shield
- Head coverings

Policy: All staff will use the appropriate personal protective equipment when performing certain tasks throughout the surgery center.

Procedure:

1. Employees working in the decontamination area should wear full PPE, to include but not limited to head coverings, shoe covers, eye protection, gown, and gloves, as the possibility of contamination by splashing is very likely. Tasks included are:
 - a. Washing instruments/equipment after surgery
 - b. Washing basins
 - c. Loading washer/disinfector
 - d. Emptying suction canisters
 - e. Mixing solutions
 - f. Pouring out expired solutions
 - g. Gathering up soiled disposables after surgery
 - h. Decontamination of the OR suite
2. Employees cleaning the autoclaves should wear full PPE, as the possibility of contamination by splashing is likely. In addition, fumes from the cleaners can be irritating to the airway passages.
3. For those performing surgical procedures, the employee should utilize:
 - a. Sterile Gloves
 - b. Face Mask to cover mouth and nose
 - c. Gown
 - d. Head covering
 - e. Shoe covers
4. For those performing tasks in pre-op and /or PACU:
 - a. When conducting any patient care or invasive procedures
 - b. Gown/mask if deemed necessary or bodily fluid splashes are anticipated



- c. Gathering trash for disposal
 - d. Gathering linen for disposal
 - e. Damp dusting with germicidal solution

5. Glove should ALWAYS BE WORN when:
 - a. Picking up any item used on a patient
 - b. When conducting any patient care or invasive procedures
 - c. Gathering trash for disposal
 - d. Gathering linen for disposal
 - e. Damp dusting with germicidal solution

6. Employees should review the OSHA manual and familiarize themselves with all the tasks that have been identified as hazardous.

7. Removed PPE should be disposed of in the appropriate waste receptacle.

8. Employees should thoroughly wash their hands and forearms after removal of PPE

9. Non-disposable PPE should be cleaned and disinfected as needed.

Henderson Hospital

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2019

I. Overview

HENDERSON HOSPITAL endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. **HENDERSON HOSPITAL** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **HENDERSON HOSPITAL** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **HENDERSON HOSPITAL** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **HENDERSON HOSPITAL**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **HENDERSON HOSPITAL** policies. **HENDERSON HOSPITAL** employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

HENDERSON HOSPITAL mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

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

HENDERSON HOSPITAL recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

HENDERSON HOSPITAL has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk

Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

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

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

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

C. Patient Safety

HENDERSON HOSPITAL has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **HENDERSON HOSPITAL** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

HENDERSON HOSPITAL PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.

- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

HENDERSON HOSPITAL is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the

Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

D. MIDAS

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. Risk Connect (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

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

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. UHSD Acute Care Division Patient Safety Priorities, Goals and Objectives for 2019

- **Surgical and Procedural Safety:**
 - **Wrong Site Surgery.**

- 5% reduction of 2019 Violence related harm events. Increase utilization of security assists with subsequent decrease in security emergency utilization which will further impact harm events.
 - Monitor through Midas EOC Dashboard, Loss Control Reports, Serious Incident debriefing and HealthStream training modules. Report quarterly with oversight by CPSC.
- **CLABSI/CAUTI Initiative**
 - **Goal:** CLABSI and CAUTI rates will be reduced by 10% each in 2019.
 - Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly with oversight by CPSC.
- **Executive Engagement in Safety/Safety Huddles**
 - **Goal:** 100% of essential safety huddle elements will be included in all hospital unit/department and Executive Safety Huddles.
 - Monitor through Observation/Mentoring Forms completed by Patient Safety Leads and Corporate resources. Report monthly with oversight by CPSC.
- **Safe Medication Use**
 - **Emergency Department Pyxis Optimization**
 - **Goal:**
 - Identify those limited emergency departments with ADCs that are not in profile mode.
 - Assess the barriers to converting those ADCs to profile mode and create a timeline for conversion by mid-Q1 2019.
 - Convert 100% of ADCs in the emergency departments to profile by Q2 2019.
 - Decrease the number of all-harm, medication events related to ADC overrides by 10% by December 2019.
 - Monitor through MIDAS reports, trigger tools, Cerner orders, and other intervention data. Report monthly with oversight by CPSC.
 - **Opioid Analgesic Event Reduction Initiative**
 - **Goal:** decrease the number of adverse drug events related to opioids by 10% by the end of 2019.
 - Monitor through Cerner, MIDAS, ICD-10 codes, and intervention data. Report monthly with oversight by CPSC.
 - **High Alert Medication Error Reduction**
 - **Goal:** 10% error reduction goal with warfarin and insulin medication administration errors.

- Monitor through MIDAS, Cerner, PSO reports, Pharmacist Interventions. Report monthly with oversight by CPSC.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls in the acute division by end of 2019.
 - Monitor through MIDAS event reporting. Report quarterly with oversight by CPSC.
- **Eliminate patient harm related to alarm fatigue or customized alarm settings.**
 - **Goal:** Zero patient harm related to alarm fatigue as evidenced by no reportable events.
 - Monitor through ART report and Midas
- **Reduce/eliminate patient infections from mishandling of flexible endoscopes after disinfection.**
 - **Goal:** Zero reported patient infections from endoscopes.
 - Monitor through monthly cultures and tracers.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

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

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

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

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected

as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that

occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				

Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				
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Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

SUBJECT: PATIENT SAFETY PLAN	Page 1 of 8
	REFERENCE #: 7046-NVREG

POLICY

- This policy applies to all employees, medical staff, contractors, patients, visitors and patients of this hospital.
- All unexpected events or occurrences involving death or serious physical or psychological injury or risk thereof are to be reported to the administrative team immediately upon identification (regardless of time of day or night).
- Any and all adverse event or medical errors require immediate action to examine the event in-depth to determine why the incident occurred and how to reduce the likelihood of recurrence.
- The governing body must ensure that the Patient Safety Program (PSP) reflects the complexity of the hospital's organization and services, including those services furnished under contract or arrangement, and focuses on the prevention and reduction of medical errors and adverse events.
- All adverse events or medical errors are errors; but not all errors are adverse events or medical errors.
- Failure to report an adverse event or medical error will be addressed through the Disciplinary process
- Event data will be preserved and collected per hospital policy.¹
- Event equipment will be preserved and removed from patient care until cleared

PATIENT SAFETY SYSTEM:

- To have a means for establishing clear expectations for identifying and detecting the prevalence and severity of incidents that impact or threaten patient safety. This includes medical errors and adverse patient events.
- To identify, implement and regularly assess the means by which incidents are prevented or when they occur. The incidents are studied to detect nonconformance and where risk points or failures are an inherent part of the process and work to remove these risk points or failures from the system.
- To address customer (patient) communication when such incidents occur, how the patients are informed and their right to know the circumstances of events.

DEFINITIONS:

- Administrative Team: Interdisciplinary organizational team, whose members have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.
- Adverse Event: An Adverse Event shall be defined as an unexpected occurrence or variation that led to death or serious physical or psychological harm. This definition includes the National Quality Forum (NQF) "never or adverse events" that are errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients.² An event that results in unintended harm to the patient by an act of commission or omission rather than by underlying disease or condition of the patient.

¹ Control of Internal and External Documents (#7067)

² NIAHO Standard; QM.7 (p 16) Adverse Event definition

SUBJECT: PATIENT SAFETY PLAN	Page 2 of 8
	REFERENCE #: 7046-NVREG

- **Medical Error:** The failure of a planned action to be completed as intended, the use of a wrong plan to achieve an aim, or the failure of an unplanned action that should have been completed, that results in an adverse event.
- **Reportable Event:** A medical error or adverse event or occurrence which the hospital is required to report to the State.
- **Root Cause Analysis:** An interdisciplinary review process for identifying the basic or contribution causal factors that underlie a variation in performance associated with an adverse event or reportable event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.

SCOPE:

List of events and occurrences to report:

- **No Harm Errors:** those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome-that do not result in a physical or psychological negative outcome or the potential for a negative outcome, for the patient.
- **Hospital Acquired Infection/Condition:** infections/conditions that are a result of treatment in a hospital or healthcare service unit.
- **Patient Fall**
- **Mild/Moderate Adverse Outcome Errors:** those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- **Any Medication Error**
- **Any Adverse Drug Reaction**
- **Hazardous Condition:** any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- **Near Miss:** any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- **Reportable Events to the State:**
 - (i) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient;
 - (ii) a perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams;
 - (iii) the suicide of a patient in a setting in which the patient received care 24 hours a day;
 - (iv) the abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant;

SUBJECT: PATIENT SAFETY PLAN	Page 3 of 8
	REFERENCE #: 7046-NVREG

- (v) the sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility;
 - (vi) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;
 - (vii) a surgical procedure on the wrong patient or on the wrong body part of a patient;
 - (viii) a foreign object accidentally left in a patient during a procedure; and
 - (ix) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
- Required by the State: a health care-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the federal Centers for Medicare and Medicaid.
 - Other events: as included in the list of adverse events identified by the National Quality Forum that is not included in the list required by the State (see Appendix A for National Quality Forum events).

PROCEDURE:

- Upon the identification of an adverse event or medical error, after the patient is safe (as applicable), the administrative team has been notified prior to leaving duty, employees, members of the medical staff and any witnesses must complete an incident occurrence and submit it to their immediate supervisor who will follow the incident reporting process.³
- Adverse events or medical errors will be reviewed by the Administrative Team within 24 hours of incident notification. The administrative team will determine if the incident warrants conducting a root cause analysis.
- The licensed independent practitioner responsible for managing the patient's care, treatment, and services, or his/her designee, shall inform the patient or their representative, within 24 hours of the adverse events or medical errors about unanticipated outcomes of care, treatment, and services related to adverse events or medical errors when the patient or their representative is not already aware of the occurrence or when further discussion is needed.
- If it is determined by the administrative team that an RCA is warranted, it will commence within five (5) business days of the decision.
- The RCA will be conducted by the administrative team, staff and licensed independent practitioners who have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.

Specifically the administrative team will:

- Complete an RCA to examine the cause and effect of the event through an impartial process.
- The RCA will focus primarily on the systems and processes, not individual performance. It will include the following elements:
 - A clear definition of the issue(s) pertaining to the event, that is, a determination of the human and other factors most directly associated with the event, and the process (es) and systems related to its occurrence.

³ Corrective/Preventive Action Plan (#7070)

SUBJECT: PATIENT SAFETY PLAN	Page 4 of 8
	REFERENCE #: 7046-NVREG

- Identification of risk points and their potential contributions to the type of event
 - Develop an action plan identifying the strategies that the hospital intends to employ to reduce the risk of similar events occurring in the future.
 - The action plan must:
 - Designate responsibility for implementation and oversight;
 - Specify time frames for implementation, analysis and follow-up
 - Include a strategy for measuring the effectiveness of the actions taken.
 - The administrative team will not, in any circumstance, delay implementation of the action plan or, as appropriate, elements of its components, over seven (7) days from the date of the completion of the RCA.
 - The administrative team will be afforded the time and resources by Quality Management Oversight to implement the approved plan.
 - If the RCA determines that the adverse event or medical error is related to an organizational systems approach or process challenge, the team will utilize the PDCA (Plan, Do, Check, Act) to design, implement and evaluate an improvement plan to correct the system issue and/or problem.⁴
- Reporting requirements:
 - The administrative team or their designee will report any and all activities of the RCA to the Quality Management Oversight
 - The administrative team or their designee will report any and all findings of the RCA to the Medical Executive Committee, and any other committees, teams, workgroups, or individuals within the organization, as appropriate to the defined issue.
 - The adverse event or medical error and/or the corrective action plan will be communicated to other organizations or individuals at sole discretion of the Chief Executive Officer or his/her designee.
- Other issues related to the RCA:
 - If the RCA finds the adverse event or medical error is to be caused by the performance and/or competence of an independent licensed practitioner holding clinical privileges, the corrective action will be managed through the supervision and direction of the Medical Executive Committee.
 - If the RCA finds the adverse event or medical error to be caused by the performance and/or competence of a clinical staff member not holding clinical privileges, or of a non-clinical staff member, then the corrective action shall be managed by the facility administrative team.

⁴ Quality Manual (#7075)

SUBJECT: PATIENT SAFETY PLAN	Page 5 of 8
	REFERENCE #: 7046-NVREG

**Appendix A
National Quality Forum
Serious Reportable Events**

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

SUBJECT: PATIENT SAFETY PLAN	Page 6 of 8
	REFERENCE #: 7046- NVREG

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)

Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

SUBJECT: PATIENT SAFETY PLAN	Page 7 of 8
	REFERENCE #: 7046-NVREG

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

SUBJECT: PATIENT SAFETY PLAN	Page 8 of 8
	REFERENCE #: 7046- NVREG

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

SUBJECT: PATIENT SAFETY PLAN	Page 1 of 8
	REFERENCE #: 7046-NVREG

POLICY

- This policy applies to all employees, medical staff, contractors, patients, visitors and patients of this hospital.
- All unexpected events or occurrences involving death or serious physical or psychological injury or risk thereof are to be reported to the administrative team immediately upon identification (regardless of time of day or night).
- Any and all adverse event or medical errors require immediate action to examine the event in-depth to determine why the incident occurred and how to reduce the likelihood of recurrence.
- The governing body must ensure that the Patient Safety Program (PSP) reflects the complexity of the hospital's organization and services, including those services furnished under contract or arrangement, and focuses on the prevention and reduction of medical errors and adverse events.
- All adverse events or medical errors are errors; but not all errors are adverse events or medical errors.
- Failure to report an adverse event or medical error will be addressed through the Disciplinary process
- Event data will be preserved and collected per hospital policy.¹
- Event equipment will be preserved and removed from patient care until cleared

PATIENT SAFETY SYSTEM:

- To have a means for establishing clear expectations for identifying and detecting the prevalence and severity of incidents that impact or threaten patient safety. This includes medical errors and adverse patient events.
- To identify, implement and regularly assess the means by which incidents are prevented or when they occur. The incidents are studied to detect nonconformance and where risk points or failures are an inherent part of the process and work to remove these risk points or failures from the system.
- To address customer (patient) communication when such incidents occur, how the patients are informed and their right to know the circumstances of events.

DEFINITIONS:

- Administrative Team: Interdisciplinary organizational team, whose members have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.
- Adverse Event: An Adverse Event shall be defined as an unexpected occurrence or variation that led to death or serious physical or psychological harm. This definition includes the National Quality Forum (NQF) "never or adverse events" that are errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients.² An event that results in unintended harm to the patient by an act of commission or omission rather than by underlying disease or condition of the patient.

¹ Control of Internal and External Documents (#7067)

² NIAHO Standard; QM.7 (p 16) Adverse Event definition

SUBJECT: PATIENT SAFETY PLAN	Page 2 of 8
	REFERENCE #: 7046-NVREG

- **Medical Error:** The failure of a planned action to be completed as intended, the use of a wrong plan to achieve an aim, or the failure of an unplanned action that should have been completed, that results in an adverse event.
- **Reportable Event:** A medical error or adverse event or occurrence which the hospital is required to report to the State.
- **Root Cause Analysis:** An interdisciplinary review process for identifying the basic or contribution causal factors that underlie a variation in performance associated with an adverse event or reportable event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.

SCOPE:

List of events and occurrences to report:

- **No Harm Errors:** those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome-that do not result in a physical or psychological negative outcome or the potential for a negative outcome, for the patient.
- **Hospital Acquired Infection/Condition:** infections/conditions that are a result of treatment in a hospital or healthcare service unit.
- **Patient Fall**
- **Mild/Moderate Adverse Outcome Errors:** those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- **Any Medication Error**
- **Any Adverse Drug Reaction**
- **Hazardous Condition:** any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- **Near Miss:** any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- **Reportable Events to the State:**
 - (i) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient;
 - (ii) a perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams;
 - (iii) the suicide of a patient in a setting in which the patient received care 24 hours a day;
 - (iv) the abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant;

SUBJECT: PATIENT SAFETY PLAN	Page 3 of 8
	REFERENCE #: 7046-NVREG

- (v) the sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility;
 - (vi) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;
 - (vii) a surgical procedure on the wrong patient or on the wrong body part of a patient;
 - (viii) a foreign object accidentally left in a patient during a procedure; and
 - (ix) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
- Required by the State: a health care-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the federal Centers for Medicare and Medicaid.
 - Other events: as included in the list of adverse events identified by the National Quality Forum that is not included in the list required by the State (see Appendix A for National Quality Forum events).

PROCEDURE:

- Upon the identification of an adverse event or medical error, after the patient is safe (as applicable), the administrative team has been notified prior to leaving duty, employees, members of the medical staff and any witnesses must complete an incident occurrence and submit it to their immediate supervisor who will follow the incident reporting process.³
- Adverse events or medical errors will be reviewed by the Administrative Team within 24 hours of incident notification. The administrative team will determine if the incident warrants conducting a root cause analysis.
- The licensed independent practitioner responsible for managing the patient's care, treatment, and services, or his/her designee, shall inform the patient or their representative, within 24 hours of the adverse events or medical errors about unanticipated outcomes of care, treatment, and services related to adverse events or medical errors when the patient or their representative is not already aware of the occurrence or when further discussion is needed.
- If it is determined by the administrative team that an RCA is warranted, it will commence within five (5) business days of the decision.
- The RCA will be conducted by the administrative team, staff and licensed independent practitioners who have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.

Specifically the administrative team will:

- Complete an RCA to examine the cause and effect of the event through an impartial process.
- The RCA will focus primarily on the systems and processes, not individual performance. It will include the following elements:
 - A clear definition of the issue(s) pertaining to the event, that is, a determination of the human and other factors most directly associated with the event, and the process (es) and systems related to its occurrence.

³ Corrective/Preventive Action Plan (#7070)

SUBJECT: PATIENT SAFETY PLAN	Page 4 of 8
	REFERENCE #: 7046-NVREG

- Identification of risk points and their potential contributions to the type of event
 - Develop an action plan identifying the strategies that the hospital intends to employ to reduce the risk of similar events occurring in the future.
 - The action plan must:
 - Designate responsibility for implementation and oversight;
 - Specify time frames for implementation, analysis and follow-up
 - Include a strategy for measuring the effectiveness of the actions taken.
 - The administrative team will not, in any circumstance, delay implementation of the action plan or, as appropriate, elements of its components, over seven (7) days from the date of the completion of the RCA.
 - The administrative team will be afforded the time and resources by Quality Management Oversight to implement the approved plan.
 - If the RCA determines that the adverse event or medical error is related to an organizational systems approach or process challenge, the team will utilize the PDCA (Plan, Do, Check, Act) to design, implement and evaluate an improvement plan to correct the system issue and/or problem.⁴
- Reporting requirements:
 - The administrative team or their designee will report any and all activities of the RCA to the Quality Management Oversight
 - The administrative team or their designee will report any and all findings of the RCA to the Medical Executive Committee, and any other committees, teams, workgroups, or individuals within the organization, as appropriate to the defined issue.
 - The adverse event or medical error and/or the corrective action plan will be communicated to other organizations or individuals at sole discretion of the Chief Executive Officer or his/her designee.
- Other issues related to the RCA:
 - If the RCA finds the adverse event or medical error is to be caused by the performance and/or competence of an independent licensed practitioner holding clinical privileges, the corrective action will be managed through the supervision and direction of the Medical Executive Committee.
 - If the RCA finds the adverse event or medical error to be caused by the performance and/or competence of a clinical staff member not holding clinical privileges, or of a non-clinical staff member, then the corrective action shall be managed by the facility administrative team.

⁴ Quality Manual (#7075)

SUBJECT: PATIENT SAFETY PLAN	Page 5 of 8
	REFERENCE #: 7046-NVREG

**Appendix A
National Quality Forum
Serious Reportable Events**

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

SUBJECT: PATIENT SAFETY PLAN	Page 6 of 8
	REFERENCE #: 7046-NVREG

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)

Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

SUBJECT: PATIENT SAFETY PLAN	Page 7 of 8
	REFERENCE #: 7046-NVREG

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

SUBJECT: PATIENT SAFETY PLAN	Page 8 of 8
	REFERENCE #: 7046- NVREG

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities



Red Rock Pain Surgery Center

QUALITY AND PATIENT SAFETY PLAN 2019



VERSION: 2

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

Patient Safety Committee/Program
Red Rock Pain Surgery Center
5915 S. Rainbow Blvd. Ste 108
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Contents

Commitment to Patient Safety 2

 Mission, Vision, and Values..... 3

Scope and Purpose 3

Roles and Responsibilities 4

 Patient Safety Committee 5

Objectives and Goals of the Quality and Patient Safety Plan 7

Components and Methods 8

 Root Cause Analysis 9

 Model for Improvement 10

 Data Collection and Reporting 11

Patient Safety Checklists and Patient Safety Policies 13

Approval of Patient Safety Plan 15

Reference 15

Appendix A: Terms and Definitions 15

Appendix C: Fishbone Diagram 19

Appendix D-1: PDSA Worksheet 20

Appendix D-2: PDSA Monthly / Quarterly Progress Report 22

Appendix E: Checklist Example: Injuries from Falls and Immobility 23

Appendix F: Policy Example 24

Commitment to Patient Safety

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

Patient Safety and Quality Improvement Plan

processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Red Rock Pain [Surgery Center](#) Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in Red Rock Pain [Surgery Center](#) are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Red Rock Pain [Surgery Center](#) has developed this Patient Safety plan.

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

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.

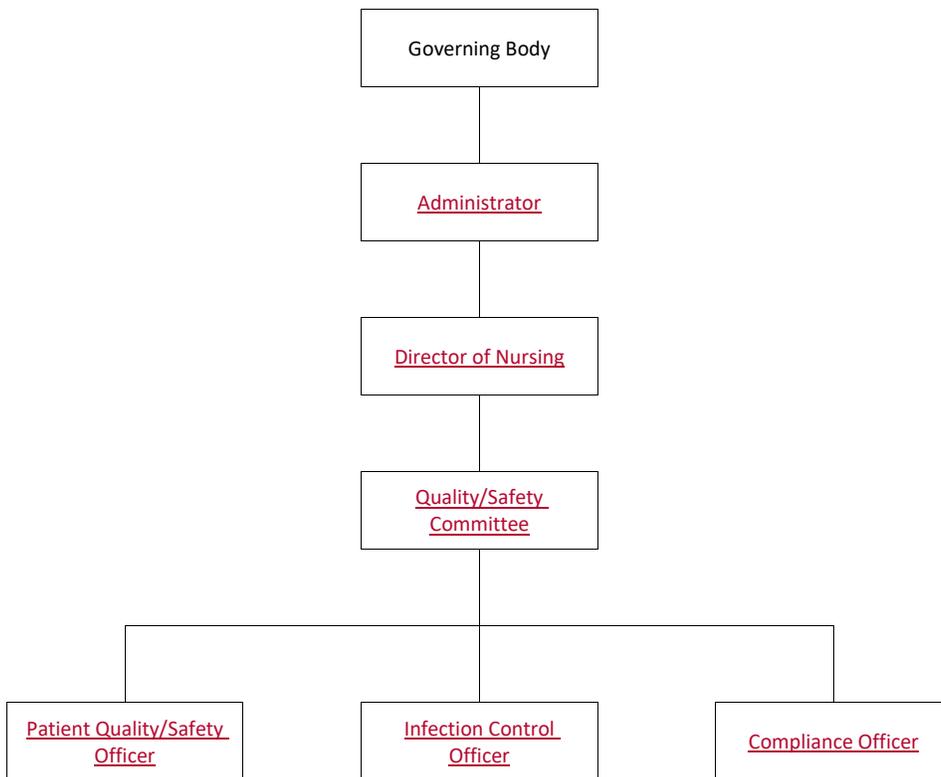
Patient Safety and Quality Improvement Plan

- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

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

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;

Patient Safety and Quality Improvement Plan

- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

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

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

The roles and responsibilities are defined below (Please modify them as needed.)

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

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Board of Managers for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.

Patient Safety and Quality Improvement Plan

- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on NRS 439.870)

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

(Additional responsibilities here if needed)

Infection Control Officer Responsibilities (based on NRS 439.873)

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

(Additional responsibilities here if needed)

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

Patient Safety and Quality Improvement Plan

- Provides oversight to the healthcare quality improvement processes and teams. Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet quarterly to accomplish the following:

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion	Responsible Party
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Patient Safety and Quality Improvement Plan

			Date	
Timely reporting of all variances	All staff will be able to independently complete variance reports	Educate all staff to the variance reporting system and forms	3/1/2018	Patient Safety Officer
Garner greater physician participation	Have physicians report all variances reported outside of the facility	Educate physicians to the patient safety plan. Encourage reporting of all variances regardless of cause.	3/15 /2018	Patient Safety Officer
Increase accountability of the Quality/Safety Committee	Increase the number of quality and safety projects at the facility	Create sub-Committees within the group to specialize in projects related to their areas.	3/15/2018	Patient Safety Officer

Components and Methods

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

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



Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in (facility name) to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

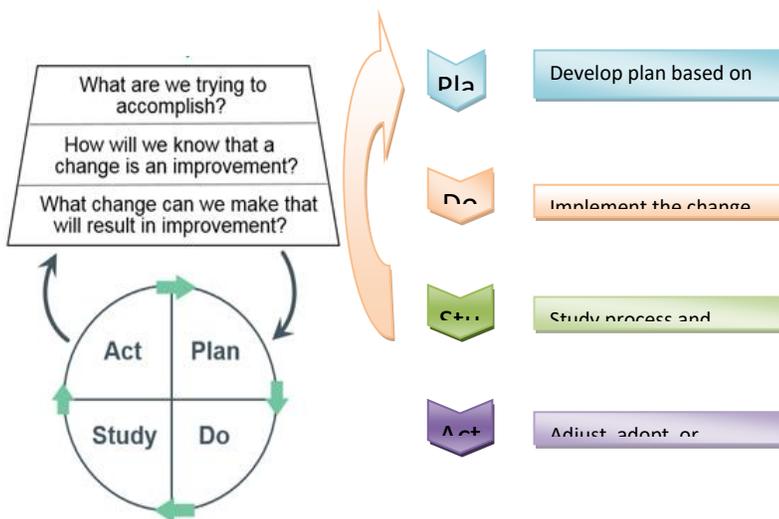
Patient Safety and Quality Improvement Plan

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why's technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
 - What is the objective of the test?

- What are the steps for the test - who, what, when?
- How will you measure the impact of the test?
- What is your plan to collect the data needed?
- What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Red Rock Pain Surgery Center is using [a paper system](#) for tracking the sentinel events, healthcare infection data, [and](#) for internal data collection.

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

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



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

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Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction

with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

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

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

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

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Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.h>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.” http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are

generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Jodi Finch RN
Administrator

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015
ACTION PLAN:				
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.
		Implemented e-MERS & PSO with UHC.	Create process for reviewing & closing reports in e-MERS. Increase number of events reported by 10%. Create process for communicating outcome of reported events.	
2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
			Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans.	Establish & implement a plan to improve performance of each leap.
4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication		Establish Patient Safety Council.	
			Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers. Revise or develop policies, procedures and protocols.	
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.			

Reference: Patient Safety Plan and Its Applicable Goals.

Patient Safety and Quality Improvement Plan

Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.

Steps	By Whom	By When	Desired Outcome

Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

Study: (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.	Summarize what was learned: success, failure, unintended consequences, etc.

Act: (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.	Describe what modifications to the plan will be made for the next cycle based on what you learned.
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle	
<input type="checkbox"/> Adopt: expanding changes throughout organization	
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle	

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Appendix F: Policy Example

<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2</p>		<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>Policy Committee</p>

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	Policy Committee

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use- PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

Section 6 Patient Safety	Green Valley Surgery Center	
Policy Name: PATIENT SAFETY PROGRAM	Page 1 of 7	
Approved: AUG 22 2017	Revised:	

POLICY:

Green Valley Surgery Center will institute and administer a comprehensive and continuous Patient Safety Program for all patients to improve patient safety and reduce risk to patients through an environment that encourages:

- Recognition of risks to patient safety and medical/health care errors
- Actions to reduce these risks
- Internal reporting of incidents and potential incidents and actions taken
- Focus on processes and systems rather than individual blame

PURPOSE:

The Patient Safety Program provides a systematic, coordinated and continuous approach to maintenance and improvement of patient safety by using established mechanisms to support responses to actual occurrences, have an ongoing proactive plan to reduce medical/health errors, and integrate patient safety as a high priority in all relevant organizational processes and services.

RESPONSIBILITY:

As with patient care, it is a coordinated and collaborative effort of the entire organization to maintain and improve patient safety.

The Governing Body approves the data-driven Patient Safety Program and ensures the program reflects the complexity of the facility's organization and services, including those services furnished under contract or arrangement and focuses on the prevention and reduction of medical/health errors and adverse effects.

The Clinical Director is responsible for the management of the Patient Safety Program by:

- Coordinating all patient safety activities
- Facilitating assessment and appropriate responses to reportable events
- Monitoring Root Cause Analysis and resulting action plans

Section 6 Patient Safety	Green Valley Surgery Center
Policy Name: PATIENT SAFETY PROGRAM	Page 2 of 7

- Serving as a liaison among the departments to assure facility wide integration of the Patient Safety Program.

Each individual employee within the organization acts as a patient advocate for safety and is responsible to report patient safety occurrences and potential occurrences to the QAPI Coordinator and the Clinical Director, who will aggregate the occurrence information and report to the Governing Body.

PROGRAM:

The scope of the Patient Safety Program includes an ongoing assessment to prevent error occurrence, maintain and improve patient safety.

Patient Safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed to prioritize organizational patient safety efforts.

Types Of Patient Safety Or Medical/Health Care Errors:

- No Harm Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
- Mild-Moderate Adverse Outcome Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- Any Medication Error
- Any Adverse Drug Reaction
- Any Transfusion Reaction
- Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one of the following (even if the outcome was not death or major permanent loss of function):
 - Suicide of a patient.
 - The sexual assault of a patient during treatment or while the patient was on the premises of the facility.
 - A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
 - Medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient.
 - A surgical procedure on the wrong patient or on the wrong body part of a patient.
 - A foreign object accidentally left in a patient during a procedure.
 - A patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
 - Near Miss – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

What To Do When A Patient Safety Error Occurs

Upon identification of a medical/health care error, the patient care provider will immediately:

- Perform necessary healthcare interventions to protect and support the patient's clinical condition.
- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of contaminated IV fluids from supply should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.

Section 6 Patient Safety	Green Valley Surgery Center
Policy Name: PATIENT SAFETY PROGRAM	Page 4 of 7

- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, piggyback fluid for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
- Report the medical/health care error to the staff member's immediate supervisor.
- Submit the incident occurrence report to the QAPI Committee per organizational policy.

Internal Reporting Of The Error/Event

Staff response to medical/health care errors is dependent upon the type of error identified:

- **No Harm Errors** – (including “no harm medication errors), staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident occurrence report form, submit the form to the QAPI Committee and notify their immediate supervisor.
- **Mild-Moderate Adverse Outcome Errors** (including medication errors), staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts in the medical record and on an incident occurrence report, submitting the report to the QAPI Committee per policy.
- **Adverse Drug Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify their immediate supervisor, document facts appropriately in the medical record and on an incident occurrence report, submitting the report to QAPI Committee per organizational policy.
- **Transfusion Reaction** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary orders. Staff will then follow the organization policy and procedure for this event.

Section 6 Patient Safety	Green Valley Surgery Center
Policy Name: PATIENT SAFETY PROGRAM	Page 5 of 7

- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify their supervisor and document the findings on an incident occurrence report which is then submitted to QAPI Committee
- **Sentinel Event** – staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure, which includes a root cause analysis and action plan.
- **Near Miss** – staff will report the near miss event to their immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to QAPI Committee.
- It is the intent of this facility to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to, their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the individual staff member’s supervisor determining the appropriate course of action to prevent error recurrence.

Root Cause Analysis

- All sentinel events and near miss occurrences will have a root cause analysis conducted to examine the cause and effect of the event through an impartial process
- A Root Cause Analysis is an interdisciplinary review process for identifying the basic or contributing causal factors that underlie a variation in performance associated with an adverse event or reportable patient safety event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.
- The QAPI Committee is responsible for conducting the root cause analysis. It will be completed within 45 days of becoming aware of one of the reportable events. They will encourage the staff members’ involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution.

Section 6 Patient Safety	Green Valley Surgery Center
Policy Name: PATIENT SAFETY PROGRAM	Page 6 of 7

A written Root Cause Analysis and “Action Plan” will be created which includes specific measures to correctly identify problems or areas of concern, identify strategies for implementing system improvements; and also includes outcome measures to indicate the effectiveness of system improvements in reducing, controlling or eliminating identified problem areas. The action plan must specifically address responsibility for implementation and oversight, time frames for implementation, and the strategy for measuring the effectiveness of the actions.

- The Joint Commission recommended “A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event” format may be used. See attached.
- Results of the entire Root Cause Analysis will be presented to the Governing Body for evaluation.

Communication of Action Plans and Root Cause Analysis

- Action Plans related to a Root Cause Analysis will be shared with the entire staff upon Completion by the QAPI Committee. Possible recommendations to update or change policy and procedures may be presented to the staff, management and Governing Body to improve patient safety.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. There will be a random record review verifying compliance with this educational process.
- Root Cause Analysis and Action Plans will be made available to the state health department representatives during onsite reviews.

Reporting Obligations

- Medical/Health care errors and occurrences, including sentinel events, will be reported internally and externally, through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

Patient Safety Program Staff Education/Training

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

Section 6 Patient Safety	Green Valley Surgery Center
Policy Name: PATIENT SAFETY PROGRAM	Page 7 of 7

- Medical errors results from multiple factors. Flawed systems or processes can combine with active failures by caregivers in the clinical setting to produce accidents and errors. Some contributing factors are:
 - Inadequate communication among team members
 - Incomplete review of patient health records and diagnostic studies
 - Traditional hierarchical and autocratic cultures
 - Patient – related decisions made only by physicians
 - Unclear instructions
 - Confusing packaging of medications and supplies
 - Time pressures and constraints, Multi-tasking
 - Failure to include the patient and family members in assessment and decision-making

- Staff will be trained about error reduction, which requires the commitment of all members of the health care team. Besides correcting the identified factors above, the following individual and facility changes will be focused on:
 - Reduce reliance on memory by using checklists and protocols.
 - Standardize processes as much as possible for procedures and other activities.
 - Focus on the safety aspects of products during the selection and evaluation process.
 - Promote safety related clinical competency.
 - Educate employees about the potential for errors and how to avoid them.
 - Creating a “Culture of Safety” whereby there is a change of environment from blaming individuals for errors to one in which errors are treated as opportunities to improve systems. This is accomplished by:
 - establishing a sense of trust among team members;
 - dissemination and verifying receipt of information to all levels of staff and management;
 - developing and supporting a proactive approach rather than a reactive approach;
 - making a sincere commitment to affirming safety as the first priority.

- Quarterly Patient Safety Program meetings will be incorporated into the QAPI Program and conducted to review any incident occurrence reports and review any new patient safety recommendations or alerts.

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
What happened?	Sentinel Event	What are the details of the event? (Brief Description)				
		When did the event occur? (Date, day of week, time)				
		What area/service was impacted?				
Why did it happen?	The process or activity in which the event occurred.	What were the steps in the process, as designed? (A flow diagram may be helpful here)				
		What steps were involved in (contributed to) the event?				
	Human factors	What human factors were relevant to the outcome?				
What were the proximate factors?	Equipment factors	How did the equipment performance affect the outcome?				
	Controllable environmental factors	What factors directly affected the outcome?				
	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influences this outcome?				
		What other areas of services are impacted?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

The following template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for “root cause” and risk reduction.

As an aid to avoiding “loose ends” the three columns on the right are provided to be checked off for later reference.

- **“Root Cause?”** - should be answered “yes” or “no” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that is relevant to the event is not a root cause, be sure that is addressed later in the analysis with a “why?” question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- **“Ask Why?”** - should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn’t occur when it should have (in other words, to drill down further). Each item checked in this column should be addressed in the analysis with a “Why?” question. If it is expected that any significant finding that are not identified as root causes themselves have “roots.”
- **“Take Action?”** - should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write down the number of the associated Action item on page 3 in the “Take Action?” column for each of the findings that requires action.

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root Cause?	Ask Why?	Take Action?
<p>What happened?</p> <p>Why did that happen? What systems and processes underlie those proximate factors?</p> <p>(common cause variation here may lead to special cause variation in dependent processes)</p>	<p>Human Resources Issues.</p>	<p>To what degree is staff properly qualified and currently competent for their responsibilities?</p>				
		<p>How did actual staffing compare with ideal levels?</p>				
		<p>What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?</p>				
		<p>To what degree is staff performance in the operating process (es) addressed?</p>				
		<p>How can orientation and in-service training be improved?</p>				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis	Questions	Findings	Root Cause?	Ask Why?	Take Action?
Information management issues.	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?				
	To what degree is communication among participants adequate?				
	To what degree was the physical environment appropriate for the processes being carried out?				
	What systems are in place to identify environmental risks?				
	What emergency and failure-mode responses have been planned and tested?				
Leadership issues: -corporate culture	To what degree is the culture conducive to risk identification and reduction?				
-encouragement communication	What are the barriers to communication of potential risk factors?				
- clear communication of priorities	To what degree is the prevention of adverse outcome communicated as a high priority?				
- uncontrollable factors	What can be done to protect against the effects of these uncontrollable factors?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Action Plan	Risk Reduction Strategies	Measures of Effectiveness
<p>For each of the findings identified in the analysis as reading an action, indicate the planned action expected, implementation data and associated measure of effectiveness OR</p>	ACTION ITEM #1	
<p>-If after consideration of such a finding a description is made not to implement as associated risk reduction strategy, indicate the rationale for not taking action at this time.</p>	ACTION ITEM #2	
<p>-Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.</p>	ACTION ITEM #3	
<p>-Consider whether pilot testing of a planned improvement should be conducted.</p>	ACTION ITEM #4	
<p>-Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.</p>	ACTION ITEM #5	
	ACTION ITEM #6	
	ACTION ITEM #7	
<p>Cite any books or journal articles that were considered in developing this analysis and action plans:</p>	ACTION ITEM #8	

SUBJECT: PATIENT SAFETY PLAN	Page 1 of 8
	REFERENCE #: 7046-NVREG

POLICY

- This policy applies to all employees, medical staff, contractors, patients, visitors and patients of this hospital.
- All unexpected events or occurrences involving death or serious physical or psychological injury or risk thereof are to be reported to the administrative team immediately upon identification (regardless of time of day or night).
- Any and all adverse event or medical errors require immediate action to examine the event in-depth to determine why the incident occurred and how to reduce the likelihood of recurrence.
- The governing body must ensure that the Patient Safety Program (PSP) reflects the complexity of the hospital's organization and services, including those services furnished under contract or arrangement, and focuses on the prevention and reduction of medical errors and adverse events.
- All adverse events or medical errors are errors; but not all errors are adverse events or medical errors.
- Failure to report an adverse event or medical error will be addressed through the Disciplinary process
- Event data will be preserved and collected per hospital policy.¹
- Event equipment will be preserved and removed from patient care until cleared

PATIENT SAFETY SYSTEM:

- To have a means for establishing clear expectations for identifying and detecting the prevalence and severity of incidents that impact or threaten patient safety. This includes medical errors and adverse patient events.
- To identify, implement and regularly assess the means by which incidents are prevented or when they occur. The incidents are studied to detect nonconformance and where risk points or failures are an inherent part of the process and work to remove these risk points or failures from the system.
- To address customer (patient) communication when such incidents occur, how the patients are informed and their right to know the circumstances of events.

DEFINITIONS:

- Administrative Team: Interdisciplinary organizational team, whose members have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.
- Adverse Event: An Adverse Event shall be defined as an unexpected occurrence or variation that led to death or serious physical or psychological harm. This definition includes the National Quality Forum (NQF) "never or adverse events" that are errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients.² An event that results in unintended harm to the patient by an act of commission or omission rather than by underlying disease or condition of the patient.

¹ Control of Internal and External Documents (#7067)

² NIAHO Standard; QM.7 (p 16) Adverse Event definition

SUBJECT: PATIENT SAFETY PLAN	Page 2 of 8
	REFERENCE #: 7046-NVREG

- **Medical Error:** The failure of a planned action to be completed as intended, the use of a wrong plan to achieve an aim, or the failure of an unplanned action that should have been completed, that results in an adverse event.
- **Reportable Event:** A medical error or adverse event or occurrence which the hospital is required to report to the State.
- **Root Cause Analysis:** An interdisciplinary review process for identifying the basic or contribution causal factors that underlie a variation in performance associated with an adverse event or reportable event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.

SCOPE:

List of events and occurrences to report:

- **No Harm Errors:** those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome-that do not result in a physical or psychological negative outcome or the potential for a negative outcome, for the patient.
- **Hospital Acquired Infection/Condition:** infections/conditions that are a result of treatment in a hospital or healthcare service unit.
- **Patient Fall**
- **Mild/Moderate Adverse Outcome Errors:** those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- **Any Medication Error**
- **Any Adverse Drug Reaction**
- **Hazardous Condition:** any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- **Near Miss:** any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- **Reportable Events to the State:**
 - (i) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient;
 - (ii) a perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams;
 - (iii) the suicide of a patient in a setting in which the patient received care 24 hours a day;
 - (iv) the abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant;

SUBJECT: PATIENT SAFETY PLAN	Page 3 of 8
	REFERENCE #: 7046-NVREG

- (v) the sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility;
 - (vi) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;
 - (vii) a surgical procedure on the wrong patient or on the wrong body part of a patient;
 - (viii) a foreign object accidentally left in a patient during a procedure; and
 - (ix) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
- Required by the State: a health care-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the federal Centers for Medicare and Medicaid.
 - Other events: as included in the list of adverse events identified by the National Quality Forum that is not included in the list required by the State (see Appendix A for National Quality Forum events).

PROCEDURE:

- Upon the identification of an adverse event or medical error, after the patient is safe (as applicable), the administrative team has been notified prior to leaving duty, employees, members of the medical staff and any witnesses must complete an incident occurrence and submit it to their immediate supervisor who will follow the incident reporting process.³
- Adverse events or medical errors will be reviewed by the Administrative Team within 24 hours of incident notification. The administrative team will determine if the incident warrants conducting a root cause analysis.
- The licensed independent practitioner responsible for managing the patient's care, treatment, and services, or his/her designee, shall inform the patient or their representative, within 24 hours of the adverse events or medical errors about unanticipated outcomes of care, treatment, and services related to adverse events or medical errors when the patient or their representative is not already aware of the occurrence or when further discussion is needed.
- If it is determined by the administrative team that an RCA is warranted, it will commence within five (5) business days of the decision.
- The RCA will be conducted by the administrative team, staff and licensed independent practitioners who have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.

Specifically the administrative team will:

- Complete an RCA to examine the cause and effect of the event through an impartial process.
- The RCA will focus primarily on the systems and processes, not individual performance. It will include the following elements:
 - A clear definition of the issue(s) pertaining to the event, that is, a determination of the human and other factors most directly associated with the event, and the process (es) and systems related to its occurrence.

³ Corrective/Preventive Action Plan (#7070)

SUBJECT: PATIENT SAFETY PLAN	Page 4 of 8
	REFERENCE #: 7046-NVREG

- Identification of risk points and their potential contributions to the type of event
 - Develop an action plan identifying the strategies that the hospital intends to employ to reduce the risk of similar events occurring in the future.
 - The action plan must:
 - Designate responsibility for implementation and oversight;
 - Specify time frames for implementation, analysis and follow-up
 - Include a strategy for measuring the effectiveness of the actions taken.
 - The administrative team will not, in any circumstance, delay implementation of the action plan or, as appropriate, elements of its components, over seven (7) days from the date of the completion of the RCA.
 - The administrative team will be afforded the time and resources by Quality Management Oversight to implement the approved plan.
 - If the RCA determines that the adverse event or medical error is related to an organizational systems approach or process challenge, the team will utilize the PDCA (Plan, Do, Check, Act) to design, implement and evaluate an improvement plan to correct the system issue and/or problem.⁴
- Reporting requirements:
 - The administrative team or their designee will report any and all activities of the RCA to the Quality Management Oversight
 - The administrative team or their designee will report any and all findings of the RCA to the Medical Executive Committee, and any other committees, teams, workgroups, or individuals within the organization, as appropriate to the defined issue.
 - The adverse event or medical error and/or the corrective action plan will be communicated to other organizations or individuals at sole discretion of the Chief Executive Officer or his/her designee.
- Other issues related to the RCA:
 - If the RCA finds the adverse event or medical error is to be caused by the performance and/or competence of an independent licensed practitioner holding clinical privileges, the corrective action will be managed through the supervision and direction of the Medical Executive Committee.
 - If the RCA finds the adverse event or medical error to be caused by the performance and/or competence of a clinical staff member not holding clinical privileges, or of a non-clinical staff member, then the corrective action shall be managed by the facility administrative team.

⁴ Quality Manual (#7075)

SUBJECT: PATIENT SAFETY PLAN	Page 5 of 8
	REFERENCE #: 7046-NVREG

**Appendix A
National Quality Forum
Serious Reportable Events**

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

SUBJECT: PATIENT SAFETY PLAN	Page 6 of 8
	REFERENCE #: 7046- NVREG

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)

Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

SUBJECT: PATIENT SAFETY PLAN	Page 7 of 8
	REFERENCE #: 7046-NVREG

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

SUBJECT: PATIENT SAFETY PLAN	Page 8 of 8
	REFERENCE #: 7046- NVREG

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

PAM Rehabilitation Hospital of Centennial Hills

QUALITY AND PATIENT SAFETY PLAN

DATE: 01/11/2019



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

**Patient Safety Committee/Program
PAM Rehabilitation Hospital of Centennial Hills
6166 North Durango Drive
Las Vegas, Nevada 89149**

**Prepared by Donna Rolshouse, R.N., C.P.H.Q.
Director of Quality Management
Patient Safety Officer**

Contents

Commitment to Patient Safety.....	3
Mission, Vision, and Values	3
Scope and Purpose.....	3
Roles and Responsibilities.....	4
Roles and Responsibilities	5
Objectives and Goals of the Quality and Patient Safety Plan	8
Components and Methods	9
Root Cause Analysis.....	10
Model for Improvement.....	11
Data Collection and Reporting.....	12
Assessment of the Quality and Patient Safety Plan	13
Patient Safety Checklists and Patient Safety Policies	13
Approval of Patient Safety Plan.....	15
Reference.....	15
Appendix A: Terms and Definitions	16
Appendix B: Patient Safety Goals	18
Appendix C: Fishbone Diagram.....	19
Appendix D-1: PDSA Worksheet.....	20
Appendix D-2: PDSA Monthly / Quarterly Progress Report	22
Appendix E: Checklist Example: Injuries from Falls and Immobility.....	23
Appendix F: Policy Example.....	24

Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision, and values, PAM Rehabilitation Hospital of Centennial Hills Patient Safety and Quality Improvement program promotes:

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

Scope and Purpose

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

- Patient safety
- Visitor safety
- Employee safety

All staff in PAM Rehabilitation Hospital of Centennial Hills are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

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

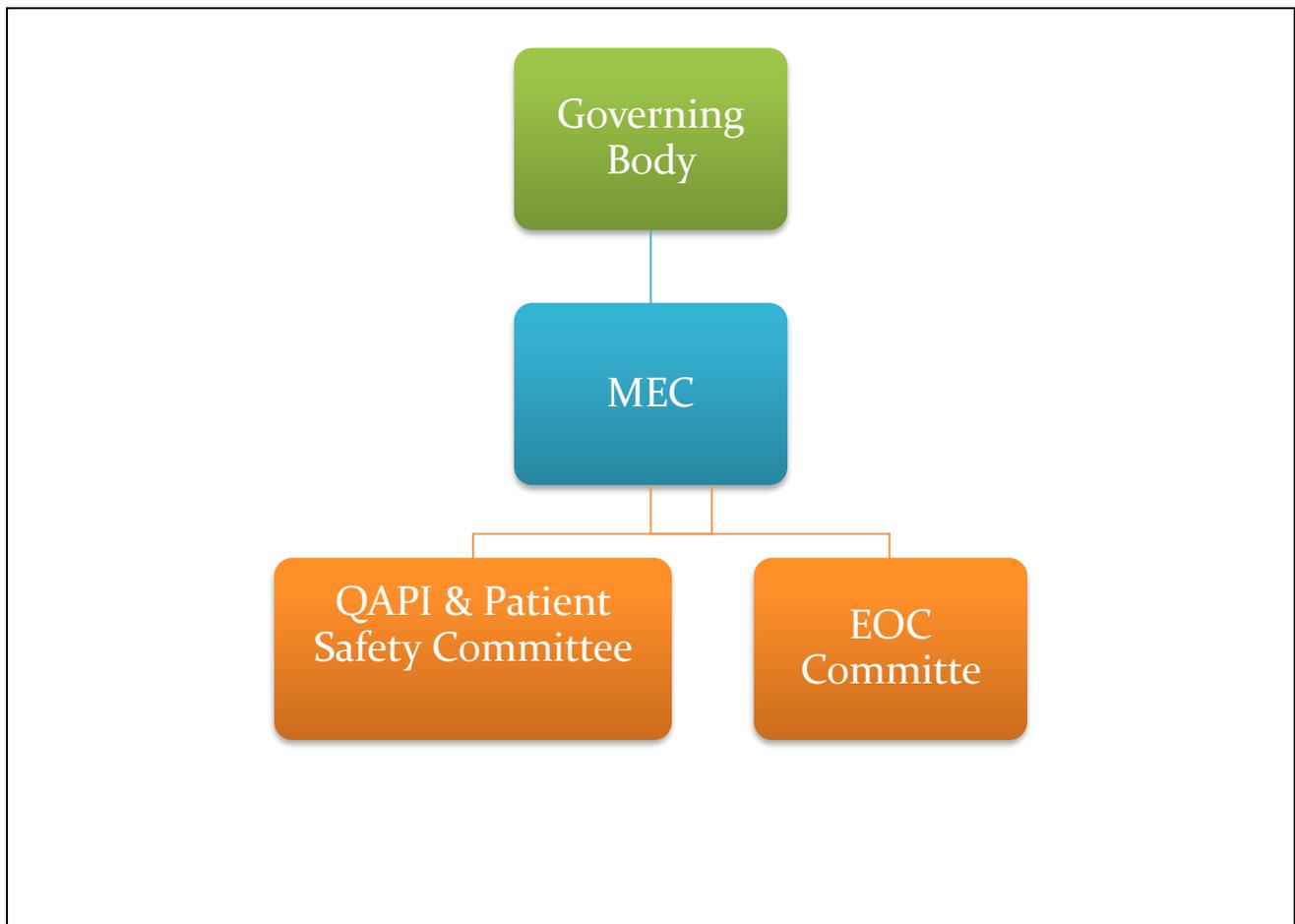
Patient Safety plan.

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

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

Roles and Responsibilities

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



Roles and Responsibilities

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

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

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

The roles and responsibilities are defined below.

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

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

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

Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

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

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

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

RCA team leader/facilitator Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

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

The Patient Safety Committee will meet monthly to accomplish the following:

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

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
 - Reviewing and analyzing the data.
 - Reviewing the RCA process and quality improvement related activities and timelines.
 - Brainstorming issues or the potential risks by using the fishbone diagrams.
 - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
 - Identifying the Plan-Do-Study-Act (PDSA) topics.
 - Discussing corrective action process and activities.
 - Discussing and presenting possible changes in procedure to improve areas indicated.
 - Identifying strengths and areas that need improvement.
 - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA effort

Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Hand hygiene compliance	90%	Observations and training, one on one coaching if indicated	12/31/2019	Entire clinical team
PPE Compliance	90%	Observations and training, one on one coaching if indicated	12/31/2019	Entire clinical team
Patient Safety with scanning medications	100%	Scan all medications, all medications will have barcode and be scanned; education and monitoring	12/31/2019	Pharmacy and Nursing
Keep falls at a minimum; no injuries	Fall rate ≤ 7.0	Risk assessments; fall precautions implemented; monitoring; huddles for data collection	12/31/2019	Nursing, therapy
Safe and successful discharges, keep LOA and acute transfers out to a minimum	Rate < 10.0	Hourly rounding; rapid responses if indicated and change in condition, post-acute huddles for information	12/31/2019	Entire clinical team
No hospital acquired pressure ulcers, =>stage 3	Zero	Daily and weekly skin assessments; education;	12/31/2019	Nursing

Components and Methods

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

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



Root Cause Analysis

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

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

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in PAM Rehabilitation Hospital of Centennial Hills to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

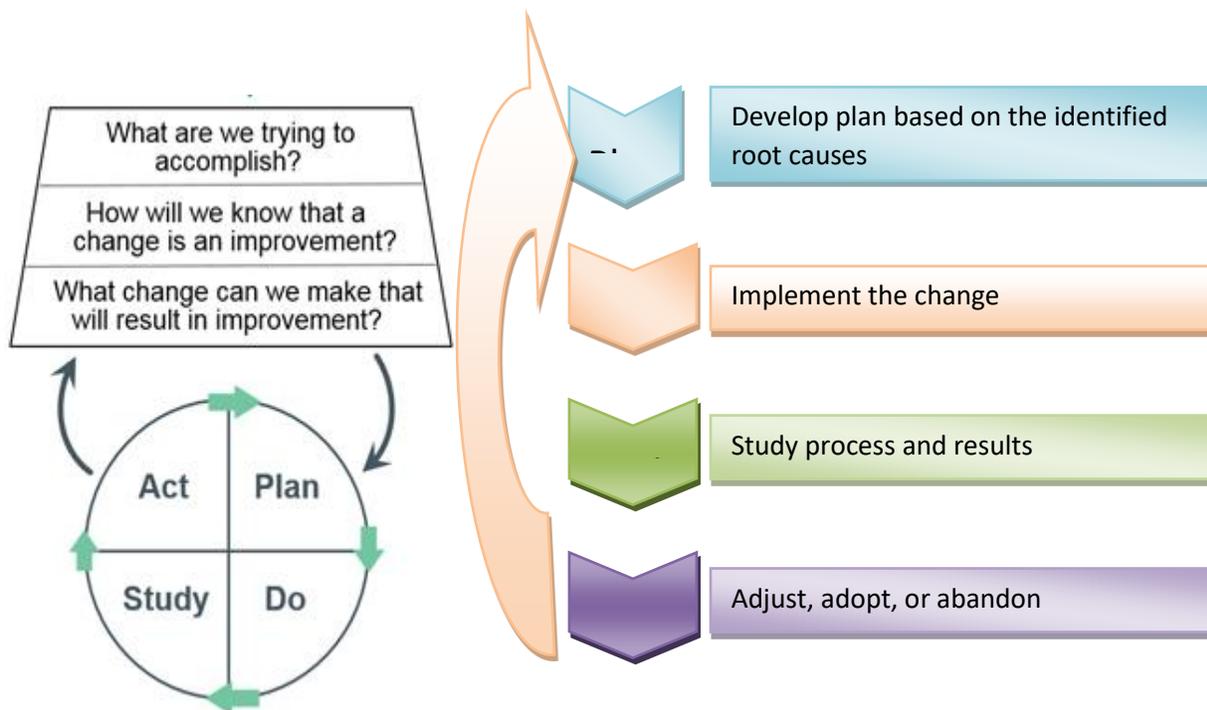
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.

- What is the objective of the test?
 - What are the steps for the test - who, what, when?
 - How will you measure the impact of the test?
 - What is your plan to collect the data needed?
 - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
 - What were the results of the test?
 - Was the cycle carried out as designed or planned?
 - What did you observe that was unplanned or expected?
 - Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
 - Did the results match your prediction?
 - What did you learn?
 - What do you need to do next?
 - Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. PAM Rehabilitation Hospital of Centennial Hills is using from RMPRO, erehab, meridian, for tracking the sentinel events, healthcare infection data, and internal data collection.

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

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

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

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

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

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

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

Approval of Patient Safety Plan

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

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

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

Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement:
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2
https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>

- Minutes of the Meeting of the Quality and Patient Safety Committee
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.
2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:
 - (a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or
 - (b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.
3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.
(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985; 254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

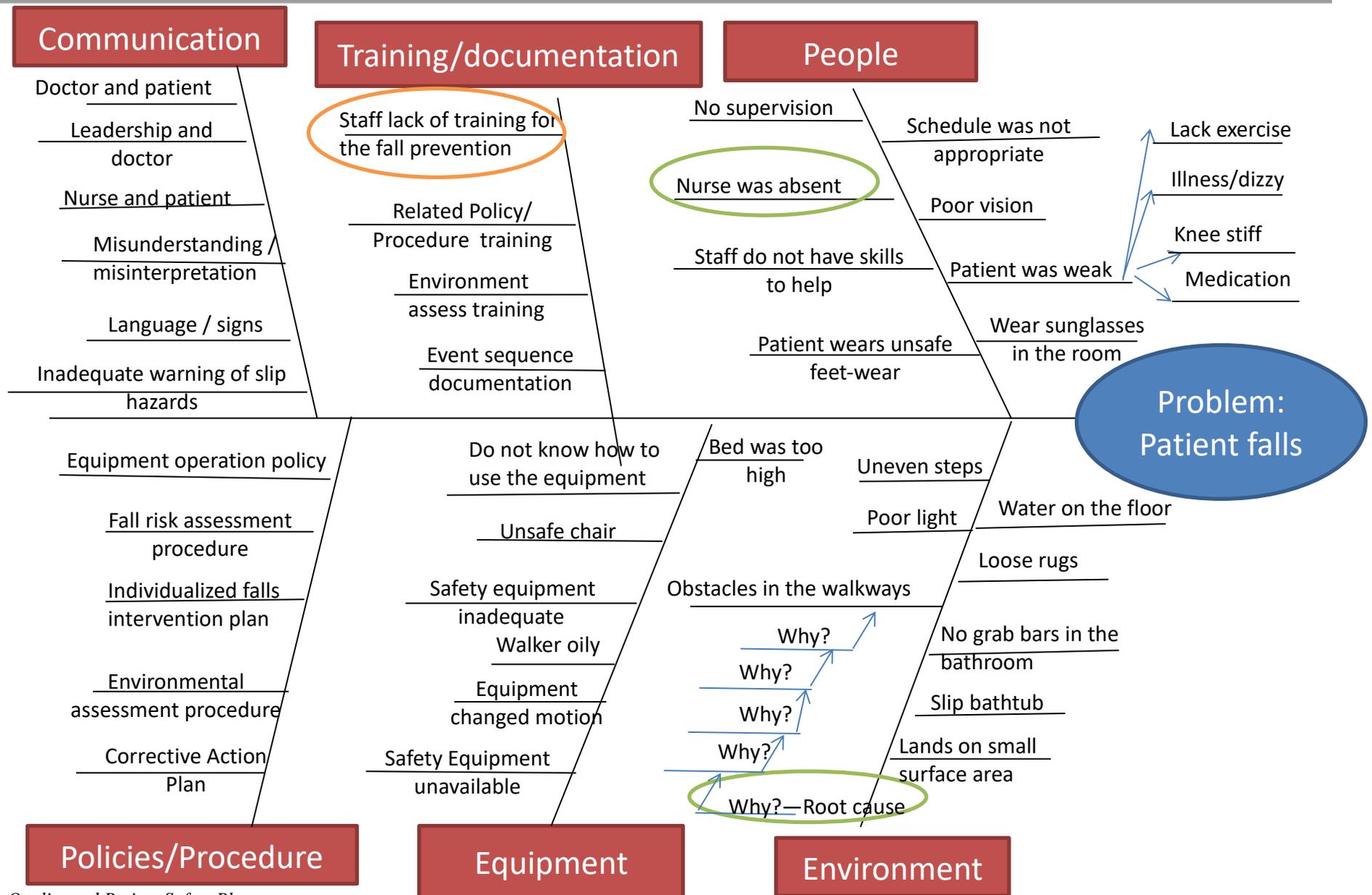
Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Patient Safety Goals

OBJECTIVE:	GOAL:	Q3 2014	Q4 2014	Q1 2015	
ACTION PLAN:					
1. Create Systems that anticipate errors & either prevent or catch them before they cause harm.	a. Enhance retrospective chart review process. b. Establish an automated surveillance process. c. Conduct a proactive risk assessment in a high risk area.		Complete an in-depth analysis of risk point utilizing the methods of FMEA.	Implement Trigger Tools. Develop automated surveillance reports in Cerner.	
		2. Establish Structures for reporting and a process for managing reports in the event reporting system.	a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization. b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events. c. Establish a process for providing feedback regarding reported events.	Implemented e-MERS & PSO with UHC.	
				Create process for reviewing & closing reports in e-MERS. Create process for communicating outcome of reported events.	Increase number of events reported by 10%.
3. Develop a Culture of Safety where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety.	a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability. b. Establish a recognition program that rewards safe practices. c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.		Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan. Include patient safety presentation in monthly New Employee Orientation. Develop 'Great Catch' awards program.	Re-evaluate culture of safety and develop action plan.	
		4. Establish Safety Priorities & Targets.	a. Develop Patient Safety Dashboard that includes national measures and benchmarks. b. Facilitate the development of action plans associated with measures not meeting benchmarks. c. Assess and improve processes related to hand-off, transition and communication	Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.	
				Complete 2014 Leapfrog Safety Survey. Develop method to track & report departmental progress and compliance of RCA action plans.	Establish & implement a plan to improve performance of each leap.
5. Charter Safety Programs through teams, workgroups or projects.	a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices. b. Reduce and eliminate variation in care.		Establish Patient Safety Council.		
			Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.		
			Revise or develop policies, procedures and protocols.		

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

Appendix C: Fishbone Diagram



Appendix D-1: PDSA Worksheet

PDSA Worksheet

Topic:			
Person Completing Worksheet:		Date:	
Telephone/ Email:		Cycle:	
Patient Safety Committee Members			
CEOs/CFOs			
Patient Safety Officer			
Infection Control Officer			
Other Medical Staff			
Other team members			
Aim: (Describe the overall SMART goal that your team wishes to achieve.)			
Plan:			
1. List the tasks needed to set up this test of change.			
2. Predict what will happen when the test is carried out.			

3. List the steps to develop the test-who, what, and when.			
Steps	By Whom	By When	Desired Outcome
Do: (Describe what actually happened when you ran your test, including any problems and unexpected findings.)			
Study: (Describe what you learned and did you meet your measurement goal?)			
Did you meet your measurement goal? Explain.		Summarize what was learned: success, failure, unintended consequences, etc.	
Act: (Describe what you concluded from this cycle.)			
Based on what was learned, please indicate what action will be considered.		Describe what modifications to the plan will be made for the next cycle based on what you learned.	
<input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle			
<input type="checkbox"/> Adopt: expanding changes throughout organization			
<input type="checkbox"/> Abandon: change approach and repeat PDSA cycle			

Appendix D-2: PDSA Monthly / Quarterly Progress Report

Event:			
Person Complete Report:		Date:	
Patient Safety Officer		Contact Information:	
Monthly / Quarterly Report			
Items	Description		
1. What is your goal?			
2. Report on the PDSA cycle			
3. What system and practices are working well? Explain.			
4. What areas for improvement did the data identify?			
5. What barriers or system issues have been encountered implementing action activities?			
6. Action plans to address the barriers or system issues			
7. Lesson learned			
8. Support needed			
9. Additional discussion			
Notes:			

Appendix E: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission	X			
Reassess risk daily and with changes in patient condition	X			
Implement patient-specific intervention to prevent falls and injury	X			
Communicate risk across the team; use handoff forms, visual cues, huddles	X			
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)	X			
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds	X			
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives	X			
Incorporate multidisciplinary input for falls	X			
Prevention from PT, OT, MD, RN and PharmD	X			
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient	X			
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls	X			

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

HOSPITAL POLICY AND INFORMATION MANUAL		
PERSONAL PROTECTIVE EQUIPMENT POLICY Page 1 of 2	Date Issued: Date Last Revised: Next Review Date: Approved By:	07/01 08/14 08/17 Policy Committee

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by hospital
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQulP5 - 1.5.1 and 1.5.2 Infection Control
- EQulP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

HOSPITAL POLICY AND INFORMATION MANUAL		
<p>PERSONAL PROTECTIVE EQUIPMENT POLICY Page 2 of 2</p>	<p>Date Issued: Date Last Revised: Next Review Date: Approved By:</p>	<p>07/01 08/14 08/17 Policy Committee</p>

Implementation:

Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

Process

Manager’s Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee’s Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

SUBJECT: PATIENT SAFETY PLAN	Page 1 of 8
	REFERENCE #: 7046-NVREG

POLICY

- This policy applies to all employees, medical staff, contractors, patients, visitors and patients of this hospital.
- All unexpected events or occurrences involving death or serious physical or psychological injury or risk thereof are to be reported to the administrative team immediately upon identification (regardless of time of day or night).
- Any and all adverse event or medical errors require immediate action to examine the event in-depth to determine why the incident occurred and how to reduce the likelihood of recurrence.
- The governing body must ensure that the Patient Safety Program (PSP) reflects the complexity of the hospital's organization and services, including those services furnished under contract or arrangement, and focuses on the prevention and reduction of medical errors and adverse events.
- All adverse events or medical errors are errors; but not all errors are adverse events or medical errors.
- Failure to report an adverse event or medical error will be addressed through the Disciplinary process
- Event data will be preserved and collected per hospital policy.¹
- Event equipment will be preserved and removed from patient care until cleared

PATIENT SAFETY SYSTEM:

- To have a means for establishing clear expectations for identifying and detecting the prevalence and severity of incidents that impact or threaten patient safety. This includes medical errors and adverse patient events.
- To identify, implement and regularly assess the means by which incidents are prevented or when they occur. The incidents are studied to detect nonconformance and where risk points or failures are an inherent part of the process and work to remove these risk points or failures from the system.
- To address customer (patient) communication when such incidents occur, how the patients are informed and their right to know the circumstances of events.

DEFINITIONS:

- Administrative Team: Interdisciplinary organizational team, whose members have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.
- Adverse Event: An Adverse Event shall be defined as an unexpected occurrence or variation that led to death or serious physical or psychological harm. This definition includes the National Quality Forum (NQF) "never or adverse events" that are errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients.² An event that results in unintended harm to the patient by an act of commission or omission rather than by underlying disease or condition of the patient.

¹ Control of Internal and External Documents (#7067)

² NIAHO Standard; QM.7 (p 16) Adverse Event definition

SUBJECT: PATIENT SAFETY PLAN	Page 2 of 8
	REFERENCE #: 7046-NVREG

- **Medical Error:** The failure of a planned action to be completed as intended, the use of a wrong plan to achieve an aim, or the failure of an unplanned action that should have been completed, that results in an adverse event.
- **Reportable Event:** A medical error or adverse event or occurrence which the hospital is required to report to the State.
- **Root Cause Analysis:** An interdisciplinary review process for identifying the basic or contribution causal factors that underlie a variation in performance associated with an adverse event or reportable event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.

SCOPE:

List of events and occurrences to report:

- **No Harm Errors:** those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome-that do not result in a physical or psychological negative outcome or the potential for a negative outcome, for the patient.
- **Hospital Acquired Infection/Condition:** infections/conditions that are a result of treatment in a hospital or healthcare service unit.
- **Patient Fall**
- **Mild/Moderate Adverse Outcome Errors:** those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- **Any Medication Error**
- **Any Adverse Drug Reaction**
- **Hazardous Condition:** any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- **Near Miss:** any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- **Reportable Events to the State:**
 - (i) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient;
 - (ii) a perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams;
 - (iii) the suicide of a patient in a setting in which the patient received care 24 hours a day;
 - (iv) the abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant;

SUBJECT: PATIENT SAFETY PLAN	Page 3 of 8
	REFERENCE #: 7046-NVREG

- (v) the sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility;
 - (vi) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;
 - (vii) a surgical procedure on the wrong patient or on the wrong body part of a patient;
 - (viii) a foreign object accidentally left in a patient during a procedure; and
 - (ix) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.
- Required by the State: a health care-associated adverse condition or event for which the Medicare program will not provide additional payment to the facility under a policy adopted by the federal Centers for Medicare and Medicaid.
 - Other events: as included in the list of adverse events identified by the National Quality Forum that is not included in the list required by the State (see Appendix A for National Quality Forum events).

PROCEDURE:

- Upon the identification of an adverse event or medical error, after the patient is safe (as applicable), the administrative team has been notified prior to leaving duty, employees, members of the medical staff and any witnesses must complete an incident occurrence and submit it to their immediate supervisor who will follow the incident reporting process.³
- Adverse events or medical errors will be reviewed by the Administrative Team within 24 hours of incident notification. The administrative team will determine if the incident warrants conducting a root cause analysis.
- The licensed independent practitioner responsible for managing the patient's care, treatment, and services, or his/her designee, shall inform the patient or their representative, within 24 hours of the adverse events or medical errors about unanticipated outcomes of care, treatment, and services related to adverse events or medical errors when the patient or their representative is not already aware of the occurrence or when further discussion is needed.
- If it is determined by the administrative team that an RCA is warranted, it will commence within five (5) business days of the decision.
- The RCA will be conducted by the administrative team, staff and licensed independent practitioners who have specific knowledge and authority to determine and correct the identified causative factors of the adverse event or medical error.

Specifically the administrative team will:

- Complete an RCA to examine the cause and effect of the event through an impartial process.
- The RCA will focus primarily on the systems and processes, not individual performance. It will include the following elements:
 - A clear definition of the issue(s) pertaining to the event, that is, a determination of the human and other factors most directly associated with the event, and the process (es) and systems related to its occurrence.

³ Corrective/Preventive Action Plan (#7070)

SUBJECT: PATIENT SAFETY PLAN	Page 4 of 8
	REFERENCE #: 7046-NVREG

- Identification of risk points and their potential contributions to the type of event
 - Develop an action plan identifying the strategies that the hospital intends to employ to reduce the risk of similar events occurring in the future.
 - The action plan must:
 - Designate responsibility for implementation and oversight;
 - Specify time frames for implementation, analysis and follow-up
 - Include a strategy for measuring the effectiveness of the actions taken.
 - The administrative team will not, in any circumstance, delay implementation of the action plan or, as appropriate, elements of its components, over seven (7) days from the date of the completion of the RCA.
 - The administrative team will be afforded the time and resources by Quality Management Oversight to implement the approved plan.
 - If the RCA determines that the adverse event or medical error is related to an organizational systems approach or process challenge, the team will utilize the PDCA (Plan, Do, Check, Act) to design, implement and evaluate an improvement plan to correct the system issue and/or problem.⁴
- Reporting requirements:
 - The administrative team or their designee will report any and all activities of the RCA to the Quality Management Oversight
 - The administrative team or their designee will report any and all findings of the RCA to the Medical Executive Committee, and any other committees, teams, workgroups, or individuals within the organization, as appropriate to the defined issue.
 - The adverse event or medical error and/or the corrective action plan will be communicated to other organizations or individuals at sole discretion of the Chief Executive Officer or his/her designee.
- Other issues related to the RCA:
 - If the RCA finds the adverse event or medical error is to be caused by the performance and/or competence of an independent licensed practitioner holding clinical privileges, the corrective action will be managed through the supervision and direction of the Medical Executive Committee.
 - If the RCA finds the adverse event or medical error to be caused by the performance and/or competence of a clinical staff member not holding clinical privileges, or of a non-clinical staff member, then the corrective action shall be managed by the facility administrative team.

⁴ Quality Manual (#7075)

SUBJECT: PATIENT SAFETY PLAN	Page 5 of 8
	REFERENCE #: 7046-NVREG

**Appendix A
National Quality Forum
Serious Reportable Events**

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

SUBJECT: PATIENT SAFETY PLAN	Page 6 of 8
	REFERENCE #: 7046- NVREG

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)

Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

SUBJECT: PATIENT SAFETY PLAN	Page 7 of 8
	REFERENCE #: 7046- NVREG

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

SUBJECT: PATIENT SAFETY PLAN	Page 8 of 8
	REFERENCE #: 7046- NVREG

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Spring Valley Surgery Center LLC

2018 Sentinel event reporting

3835 S. Jones Blvd. Las Vegas NV 89103 License #: 3421

2705 W. Horizon Ridge Pkwy Henderson NV 89052 License #: 5491

7175 N. Durango Drive Las Vegas NV 89149 License #: 7592

1900 N. Nellis Blvd Las Vegas NV 89115 License #: 7891

1050 E. Sahara Ave Las Vegas NV 89104 License #: 8688

8828 Mohawk Street Las Vegas NV 89139 License #: 8787

Safety committee:

The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the Federal, State, Local and OSHA guidelines. The “Safety Plan” includes identification, evaluation and prevention of workplace hazards relating to the elements and specific criteria. The safety management of the Facility is composed of several elements regarding the safety features necessary for the protection and security of its patients and healthcare workers.

These elements are composed of two parts; one “Life Safety Enterprise Safety Plan” which is wide in scope, organizational and effectiveness, and the “Environmental Safety Management” which oversees the working environment elements of the Facility. These areas overlap each other but also provide individual elements which manage the overall security and safety of the Facility. A report from the Safety Committee is provided quarterly to the Medical Executive Committee (MEC) and onto the Governing Board. The Safety Committee meets and discusses how to improve and/or maintain patient and employee well-being and safety, items discussed range from falls to how to properly lift boxes, and the execution of a disaster drills, etcetera. If any incidents have occurred they will be discussed in detail, and prevention and safety will be implemented.

Desert View

Risk Management/ Patient Safety Plan

Nevada Acute Care Division

Revised 1/2019

I. Overview

Desert View endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. Desert View operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that Desert View remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by Desert View to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan ("Plan") provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at Desert View. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the "Just Culture" concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with Desert View policies. Desert View employees, contractors, vendors, and members of each facility's medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.
- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

II. Mission and Vision

Desert View mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

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

Desert View recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

III. ROLES AND RESPONSIBILITIES

A. Risk Management/Patient Safety Officer

Desert View has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated

with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) includes:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

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

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

C. Patient Safety

Desert View has an established Patient Safety Councils (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. Desert View has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to ClearSight (STARS) and Midas) to maintain and manage PSWP.

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully.

I. Facility Patient Safety Committee

Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

Duties and Responsibilities:

Desert View PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.

- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
 - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
 - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
 - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, the Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

II. Patient Safety Advisories

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Desert View is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

Element I. Administration of the Risk Management Program: The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical

staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

Element II. Risk Identification: Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

Element III. Risk Education: Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

Element IV. Patient Safety Initiative: Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC) at each facility. The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

Element V. Patient Safety Priority: Root Cause Analysis (RCA): The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

Element VI. Environment of Care; Safety and Security Programs: The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

Element VII. Claims and Litigation Management: The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

Element VIII. Patient Safety Organization (PSO): Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

D. CCS

The CCD system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions. The facility enters incidents into CCD through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

E. Risk Connect (STARS)

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the Facility's RM to the Governing Board of all claims activities.

F. Event Notification Site

The Risk Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and corporate management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

G. Root Cause Analysis (RCA)

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or

contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



H. Patient Safety Checklists

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications;
 - Instructions concerning aftercare;
 - Any other instructions concerning his or her care upon discharge; and
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix B.**)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

<http://www.who.int/patientsafety/implementation/checklists/en/>

I. Patient Safety Policies

The patient safety policies must include, without limitation:

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

J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories

IV. UHSD Acute Care Division Patient Safety Priorities, Goals and Objectives for 2019

- **Surgical and Procedural Safety:**
 - **Wrong Site Surgery.**

- **Opioid Analgesic Event Reduction Initiative**
 - **Goal:** decrease the number of adverse drug events related to opioids by 10% by the end of 2019.
- **High Alert Medication Error Reduction**
 - **Goal:** 10% error reduction goal with warfarin and insulin medication administration errors.
- **Reduce Falls and Falls with Injury**
 - **Goal:** 10 % reduction in the number of falls in the acute division by end of 2019.

V. Monitoring and Accountability

A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

B. Patient Safety Council

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed minutes and detailed feedback is provided to coach the committee on their form and function.

C. Dashboards

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure, risk management education, events that meet the ECRI Top Patient Safety Concerns, and environment of care concerns.

VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- There is a framework that advances a “Just Culture”
- Accountability is promoted when acts of “at risk” or “reckless behavior” occur resulting in potential/actual adverse outcomes;
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action;
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

VII. Confidentiality

All patient safety/risk management work products are considered Patient Safety Work Products (PSWP) as defined by federal guidelines governing Patient Safety Organizations (PSO). All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities.

VIII. Approval of Patient Safety Plan

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

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

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

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods

toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and

- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical facility ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

**Southwest Medical,
Part of Optum Care**

PATIENT SAFETY PLAN

MARCH 1 2019



Southwest Medical™
Part of OptumCare™

The Southwest Medical Patient Safety committee/team created the plan and revises/updates it annually. Implementation of this plan is intended to optimize healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, and reduce the medical/healthcare errors and /or preventable events

Patient Safety Committee/Program
Southwest Medical, Part of Optum Care
Las Vegas, Nevada

Contents

Commitment to Patient Safety.....	3
Mission, Vision, Values.....	3
Scope and Purpose.....	3
Roles and Responsibilities.....	4
Objectives.....	11
Components and Methods.....	11
Root Cause Analysis.....	12
Performance Improvement Model.....	12
Data Collection.....	13
Reporting.....	13
Plan Assessment.....	14
Patient Safety Checklists and Polices.....	14
Plan Approval.....	15
References.....	16
Terms and Definitions.....	17

Commitment to Patient Safety

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

Mission, Vision, and Values

In support of our mission, vision and values, Southwest Medical's Patient Safety and Quality Improvement program promotes:

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

Plan Scope and Purpose

The scope of the Patient Safety Committee organizational-wide and includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

The Committee provides oversight for patient safety activities, infection control activities, initiatives to promote patient safety and monitoring and review of medical/healthcare errors/potential errors involving patients, visitors, SMA staff, students and volunteers

All staff members at Southwest Medical are expected to fully support and participate in this plan and devote their expertise, knowledge, vision, skill, and insight to the patient safety and healthcare quality improvement process

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering a culture of safety through personal example by:

- Emphasizing patient safety as an organizational priority
- Providing education to medical and facility staff regarding the commitment to reduction of medical errors
- Supporting proactive reduction in medical/health care errors
- Integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services

The purpose of the Patient Safety Plan is:

- To address patient safety related concerns and challenges
- To reduce risk
- To respect the dignity of those Southwest Medical serves by assuring a safe environment
- To periodically evaluate and revise the program to better serve patients and their families

Roles and Responsibilities

Southwest Medical created an organization-wide Patient Safety Plan that includes the medical facilities (Surgery Centers) as directed by [NRS 439.875](#) a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully

The Southwest Medical Patient Safety Committee

- Is a standing confidential interdisciplinary committee formed to manage the Southwest Medical’s Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach
- Will meet monthly to assure maintenance and improvement of patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Will report and discuss events including:
 - Number of sentinel events from previous calendar quarter
 - Number of severe infections from previous calendar quarter
 - Corrective action plans
 - Corrective action plan evaluation
 - Patient safety policies and checklists
- Will monitor and document the effectiveness of the patient safety policy
- Will evaluate patient safety policies and checklists at least annually
- Will revise patient safety policies and checklists as needed
- Will convene a RCA meeting/team as necessary
- Review the RCA process and quality improvement related activities and timelines
- Identify barriers and technical assistance needs for supporting the RCA efforts
- Discuss corrective action process and activities



Patient Safety Committee Membership

In accordance with [NRS 439.875](#), the Patient Safety Committee will include:

- The Patient Safety Officer
- The Infection Prevention and Employee Health Medical Director

- At least three providers of healthcare who treat patients , including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff
 - Medical Director Specialties
 - Medical Director Primary Care
 - Medical Director On Demand Medicine
 - Medical Director Clinical Education Programs
 - Medical Director Surgery Centers
 - Associate Vice President Surgery Centers (RN and Administrator)
 - Chief Nursing Officer
 - RN Executive Director On-Demand Medicine
 - RN Director Specialties
 - Director Imaging Services
 - Pharmacy Consultant (PharmD)
 - RN Managers Surgery Centers
 - RN Clinical Quality
 - Infection Prevention RN
- One member of the governing body
- Optum Legal
- Vice Presidents Clinic Operations
- UHG Safety Regional Manager

Patient Safety Committee Responsibilities_(based on [NRS 439.875](#) and [NRS 439.877](#))

The Patient Safety Committee is a standing confidential interdisciplinary committee formed that manages the Southwest Medical’s Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach

- Evaluating and improving the quality of care rendered by Southwest Medical
- Collecting data and evaluating aggregate data related to individual occurrences in order to utilize performance improvement methodologies to promote patient safety and infection prevention
- Maintaining and improving patient safety with the establishment of plans, processes and mechanisms involved in the provision of the patient care
- Monitoring and documenting the effectiveness of the patient identification policy
- On or before July 1 of each year, submitting a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#)
- Receiving reports from the Patient Safety Officer pursuant to [NRS 439.870](#)
- Evaluating actions of the Patient Safety Officer in connection with all reports of potential or actual sentinel events
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to improve the safety of patients who receive treatment
- Reviewing and evaluating the quality of measures carried out by Southwest Medical to prevent and control infections
- Making recommendations to the governing body to reduce the number and severity of sentinel events and infections that occur
- At least once each quarter, reporting to the governing body regarding
 - The number of sentinel events at the medical facility (Surgery Centers) during the preceding calendar quarter
 - The number and severity of infections at the medical facility (Surgery Centers) during the preceding calendar quarter
 - Any recommendations to reduce the number and severity of sentinel events and infections

- Adopting patient safety checklists and patient safety policies as required by [NRS 439.877](#), reviewing checklists and policies annually and revising the checklists and policies as necessary
- Directing root cause analysis teams when indicated
- Providing oversight/direction for Surgery Centers QAPI program and quality studies
- Providing oversight/direction for the Surgery Centers participation in NHSN
- Providing oversight and monitoring for the Optum Practice Health and Safety Clinical Assessment Process

Patient Safety Officer Responsibilities ([based on NRS 439.870](#))

- Chair the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#)
- Take such action as necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility
- Report to the Patient Safety Committee regarding any action taken in accordance with the responsibilities above
- Promote compliance with patient safety standards and initiatives
- Reinforce expectations of the Patient Safety Plan
- Accept accountability for measurably improving safety and reducing errors
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors

Infection Prevention Officer Responsibilities ([based on NRS 439.873](#))

- Serve on the Patient Safety Committee
- Liaison with Southwest Medical clinical leadership including surgery center leadership, other quality committees and the Board of Directors
- Provide medical direction as indicated (for both patient and employee infection control issues)
- Monitor the occurrences of infections to determine the number and severity of infections
- Report to the Patient Safety Committee concerning the number and severity of infections
- Take such action as necessary to prevent and control infections alleged to have occurred
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program
- Ensure compliance with current infection prevention and control standards
- Direct infection prevention initiatives
- Reinforce expectations of the Infection Control program
- Complete at least four hours of continuing education each year on topics relating to current practices in infection control and prevention
- Be a certified Infection Preventionist or complete a nationally recognized basic training program in infection control

RCA Team/Meeting

Will meet as needed to:

- Define the healthcare issues or potential risks
- Conduct Root Cause Analysis
- Review and analyze data
- Brainstorm issues or the potential risks by using fishbone diagrams or the 5 *Whys* technique
- Identify the contributing factors
- Develop Corrective Action Plan
- Identify Plan-Do-Check -Act (PDCA) topics

- Discuss and present possible changes in procedure to improve areas indicated
- Identify strengths and areas that need improvement
- Develop strategies, solutions, and next steps

RCA Team Leader Responsibilities

- Organize and coordinate the RCA process
- Assemble and encourage a supportive and proactive team
- Assign investigative and implementation tasks to the team members
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership
- Monitor goals and progress towards completion of the Corrective Action Plans
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements

Root Cause Analysis (RCA) Team Responsibilities

- Root cause interviews, analysis, investigation and corrective action plan implementations
- Participate in the RCA meetings and discussions
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders

Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process
- Develop and foster a safe learning and improving culture
- Provide oversight to healthcare quality improvement processes and teams
- Plan, discuss and generate patient safety goals and activities

Quality Studies -Process Analysis (Surgery Centers)

The Surgery Centers will complete quality studies each year that include:

1. A statement of the purpose of the QI activity that includes a description of the known or suspected problem and explained significance to the SSC
2. Identification of the performance goal against which SSC will compare current performance
3. Description of the data that will be collected in order to determine the SSC's current performance
4. Evidence of Data Collection
5. Data analysis that describes findings about the frequency, severity and source of issue
6. Comparison of the SSC's current performance against identified performance goal
7. Implementation of corrective action
8. Re-measurement to objectively determine whether corrective actions achieved and sustained improvement
9. Implementation of any additional corrective action to achieve and/or sustain improved performance (and plan for on-going re-measurement)
10. Communication of findings to SSC Leadership, The Patient Safety Committee, the Board of Directors and SSC staff and incorporating findings into educational activities

For quality studies, the Surgery Center(s) may base topic selection on information published by accrediting bodies, National Patient Safety Goals and/or other sources of information including risk management, performance improvement, quality assurance, infection prevention and control, patient/family suggestions/expectations or process outcomes

The Surgery Centers quality studies will focus on redesign or implementation of new processes to incorporate patient safety principles and will place an emphasis on the important facility and patient care functions of:

- Rights of Patients
- Governance
- Administration
- Quality of Care
- Quality Management and Improvement
- Clinical Records and Health Information
- Infection Prevention and Control and Safety
- Facilities and Environment
- Anesthesia Services
- Surgical and Related Services
- Pharmaceutical Services
- Pathology and Medical Laboratory Services
- Diagnostic and Other Imaging Services

Infection Prevention Program

- The purpose of the Infection Control Programs is to prevent and control infections
- The Infection Control Program and the surgery Centers Infection Control Program (SSC and SCT 1600-3 Infection Control Program for Southwest Medical Surgery Center) are components of the Patient Safety Plan
- The Infection Control Programs are based on current guidelines developed by nationally recognized infection control organizations
- The Infection Control Professionals will report regularly on the number and severity of infections that occurred in the prior quarter

Infection Prevention RN

Southwest Medical will maintain at least one Registered Nurse with training and education in infection prevention and control. While supporting the entire organization, the Infection Prevention RN will dedicate specific hours to the SSC

NHSN

- The medical facilities (Surgery Centers) will participate in the CDC's National Healthcare Surveillance Network
- Infection Prevention staff will report aggregate data and patient follow-up to the Patient Safety Committee at regularly scheduled intervals

Medical/Health Care Error

- Staff will immediately report the event to supervisor

The supervisor will:

- Immediately communicate the event through appropriate channels to the Patient Safety Officer; should this occur during off-hours, the supervisor/designee will leave a voice mail message for the Patient Safety Officer
- Initiate investigation and follow-up actions
- Staff will complete the Incident/Occurrence Report or Quality of Care form
- Staff will obtain required orders to support the patient's clinical condition
- Staff/supervisor will notify the UHG Safety Liaison of any situations of potential risk to others
- The Patient Safety Officer will follow usual protocols to investigate the error and coordinate the factual information/investigation for presentation, review and action by the Patient Safety Committee and/or other quality committees as applicable

Identification and Reporting

- SMA Policy 1600-29 (Sentinel Event Policy) and SMA Policy 190-4 (Incident Occurrence Reporting Policy) will describe the mechanism for identification and reporting a Sentinel Event/other medical error
- Southwest Medical will promote willingness of staff to report and will support a Just Culture that focuses on process not individuals

Root Cause Analysis

- The Patient Safety Committee/Patient Safety Officer will provide oversight and direction for any root cause analysis of facility processes conducted for either Sentinel Events or near miss events
- The Patient Safety Officer will act as the liaison to quality committees and the Board of Directors for review/recommendations

Staff Involvement

As Southwest Medical actively supports the concept that errors occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

- A non-punitive approach and without fear of reprisal
- Voluntary participation in the root-cause analysis for educational purposes and prevention of further occurrences

Reporting Requirements/Sentinel Event Reporting

- The Patient Safety Officer will direct reporting sentinel events to the Patient Safety Committee
- The Patient Safety Officer will direct reporting of any sentinel event at a medical facility per state of Nevada requirements as defined in NRS (Nevada Revised Statutes) and NAC (Nevada Administrative Code)
- The Patient Safety Officer will direct reporting the number of sentinel events and recommendations to reduce the number or severity of sentinel events to the SMA Board of Directors
- The Patient Safety Officer/Committee will provide education and support to providers to ensure providers report the occurrence of a sentinel event resulting from any surgery to the Board within fourteen days after the occurrence of the sentinel event
- The Patient Safety Committee shall evaluate the actions of the Patient Safety Officer in connection with the reporting of sentinel events
- The Patient Safety Committee shall make recommendations to the SMA Board of Directors to reduce the number and severity of sentinel events and infections that occur at the facility

HealthCare Acquired Infections (HAI) Reporting

The Patient Safety Officer/Committee will provide education and support to providers to ensure if a provider identifies a patient with an infection, the provider will notify, within five days or as soon as practicable, the patient or the legal guardian or other person authorized by the patient to receive such information that the patient has an infection

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand the notification may be delayed if the patient does not have a legal guardian, has not authorized any other person to receive such information and:

- Is not capable of understanding the information
- Is not conscious
- In the provider's judgment, the notification is likely to result in the patient harming himself

The Patient Safety Officer/Committee will provide education and support to providers so that providers understand if the notification is delayed, the information must be provided as soon as practicable after:

- The patient is capable of understanding the information

- The patient regains consciousness
- In the judgment of the provider, the patient is not likely to harm himself if informed about the infection
- A legal guardian or other person authorized to receive such information is available

Internal Reporting

The Patient Safety Committee will report internally to provide a comprehensive view of both the clinical and operational safety activity of the organization by submitting Patient Safety Committee minutes/reports to the SMA Board of Directors

The Patient Safety Committee will include ongoing activities such as data collection and analysis, actions taken and monitoring for the effectiveness of actions

External Reporting

The Patient Safety Committee will report externally in accordance with all state, federal and regulatory body rules, regulations and requirements.

- On or before March 1 of each year, The Patient Safety Committee will submit an annual sentinel event report to the Office of Public Health Informatics and Epidemiology, Bureau of Health Statistics, Planning, Epidemiology and Response, Nevada State Health Division
- The Surgery Centers will participate in the CDC National Healthcare Surveillance Network per State of Nevada NRS and NAC

Annual Report

The Patient Safety Officer will report to the SMA Board of Directors and will include:

- Defining the scope of occurrences including sentinel events, near misses and serious occurrences
- Demonstrating a pro-active component of the patient safety program through selection of high risk or problem prone processes for ongoing measurement and analysis
- Reporting results ongoing measurement and analysis of the high-risk or error-prone processes
- Describing how the function of process design incorporates patient safety using specific examples of process design or redesign that include patient safety principles
- Describing the process for soliciting and obtaining input for improving patient safety from patient/families
- Describing staff willingness to report medical/health care errors
- Describing the procedures for communication with patients/families about adverse events or unanticipated outcomes of care
- Describing examples of ongoing in-service, education and training programs to maintain and improve staff competence and support an interdisciplinary approach to patient care

Medical Facility (Surgery Centers) Reporting Requirements

The Patient Safety Officer/Committee will report to the appropriate licensing Board, within five days, after a change in the privileges of a physician, perfusionist, physician assistant or practitioner of respiratory care that is based on:

- An investigation of the mental, medical or psychological competency of the physician, perfusionist, physician assistant or practitioner of respiratory care
- Suspected or alleged substance abuse in any form by a physician, perfusionist, physician assistant or practitioner of respiratory care

Public Disclosure

The Surgery Centers will provide the name of each physician who performed a surgical procedure at the Surgery Centers, the total number of surgical procedures performed by the physician, reported by type of medical treatment, principal diagnosis, if the information is available, by principle surgical procedure and secondary surgical procedure (SB340)

Objectives Patient Safety Plan

Objective
Encourage organizational learning about medical/health care errors
Incorporate recognition of patient safety as an integral job responsibility
Include patient safety into job specific competencies
Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame
Involve patients in decisions about their health care and promote open communication about medical errors/consequences which occur
Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
Support sharing of knowledge to effect behavioral changes in and within SMA

Components and Methods

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

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



Root Cause Analysis

- A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals
- Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis
- Root Cause Analysis and action plan framework table was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used at Southwest Medical to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

Fishbone Diagram

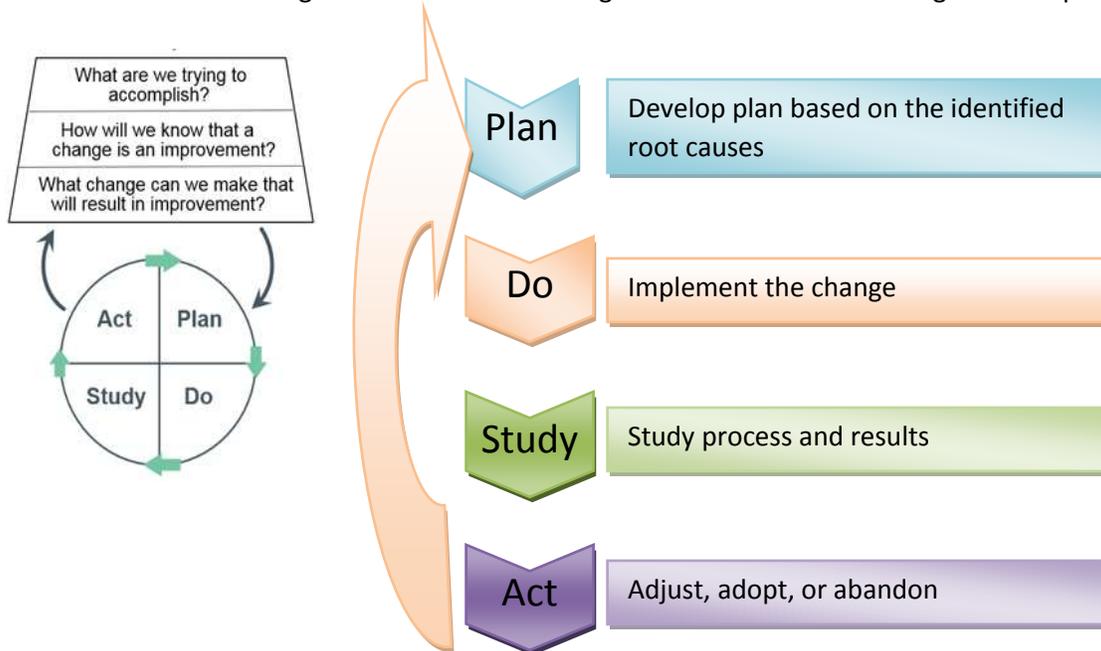
Once the problems are identified, a Fishbone Diagram can be used for analyzing the problems. Southwest Medical can use the fishbone diagram individually to analyze the root causes or can use it with the Root Cause Analysis and action plan framework table

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories include: people, methods, materials, measurements, education, procedures, process, location and environment.

RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes

Model for Improvement

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



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions:
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance:
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance:
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Southwest Medical will track sentinel events, healthcare infection data and other internal data collection

External data sources are those data sources which are collected outside the supervisory structure of the case. Southwest Medical may use external data from:

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

Ongoing Reporting and Review

The Patient Safety Committee will review Elements of the Patient Safety Plan at scheduled intervals

Monthly	Quarterly	Annually
<ol style="list-style-type: none"> 1. Sentinel event monthly report 2. Severity of infection report 3. RCA assessment 4. Optum Practice Health and Safety Clinical Compliance and Infection Prevention Clinic Assessments 	<ol style="list-style-type: none"> 1. Incidents-including sentinel event quarterly report 2. Severity of infection report 3. Review and evaluate the measure of improvement of patient safety 4. Review and evaluate the measurement to prevent and control infections 5. Quality reports including: <ul style="list-style-type: none"> • Environment of Care Standards • GI Staff Performance and HLD • Hand Hygiene • Infection Prevention • Sterilization • Pharmacy Standards 	<ol style="list-style-type: none"> 1. Quality and Patient Safety Plan update 2. Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Southwest Medical will review and evaluate the Patient Safety Plan at least annually

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the Patient Safety Plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility
- Other personnel of the facility who provide treatment or assistance to patients
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, environmental services at any medical facility
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients

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

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary
- A checklist used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
 - Proper instructions concerning prescription medications
 - Instructions concerning aftercare
 - Any other instructions concerning his or her care upon discharge
 - Any other checklists which may be appropriate to ensure the safety of patients at the facility

The patient safety policies must include, without limitation:

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

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

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

Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA)

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist

Approval of Patient Safety Plan

According to [NRS 439.865](#), Southwest Medical will submit its Patient Safety Plan to the Governing Board for approval. After the patient safety plan is approved, Southwest Medical will notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan

Southwest Medical will review and update the plan annually in accordance with State of Nevada requirements

Southwest Medical, according to [NRS 439.843](#), will submit the most current copy of the Patient Safety Plan on or before March 1 of each year, to the Division of Public and Behavioral Health

References

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

Terms and Definitions

Patient Safety

The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum
2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:
 - January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or
 - July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published
3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Medical Harm

The Institute for Healthcare Improvement (IHI) defines medical harm as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

Facility-Associated Infection: (NRS 439.802)

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections
- Ventilator-associated pneumonia
- Central line-related bloodstream infections
- Urinary tract infections
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#)

(Added to NRS by [2005, 599](#); A [2009, 553](#))

Medical Facility (NRS 439.805)

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

Near Miss

An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update)

Mandatory Reporting

Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk

Risk is the possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

Preventable Event

Preventable event describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infections (CAUTI)

A CAUTI is a urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI)

A CLABSI is a primary bloodstream infection that is associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection

Reno Behavioral Healthcare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 1 OF: 10
	EFFECTIVE: 02/2018
REVIEWED: 2/2019	REVISED: 2/2019

I. PURPOSE

The purpose of the organizational Patient Safety Plan at the hospital is to improve patient safety and reduce risk to patients through an environment that encourages:

- Integration of safety priorities into all relevant organization processes, functions, services, departments and programs
- Recognition and acknowledgment of risks to patient safety and medical/health care errors
- The initiation of actions to reduce these risks
- The internal and external reporting of what has been found and the actions taken
- A focus on processes and systems, and the reduction of process and system failures through use of failure mode effect analysis
- Minimization of individual blame or retribution for involvement in a medical/health care error
- Organizational learning about medical/health care errors
- Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations
- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to potential or actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at the hospital. The Patient Safety Plan, developed by the interdisciplinary Safety/Environment of Care Committee and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

Reno Behavioral Healthcare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 2 OF: 10
	EFFECTIVE: 02/2018
REVIEWED: 2/2019	REVISED: 2/2019

II. PATIENT SAFETY PLAN

- Scope of Activities:
 - The scope of the Patient Safety Plan includes ongoing proactive risk assessments, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety.
 - Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis, maybe, but not limited to:
 - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
 - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
 - Any Medication Variance
 - Any Adverse Drug Reaction
 - Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
 - Sentinel Event: The following events as outlined on NQF Serious Reportable Events in Healthcare:
 - Surgical Invasive Procedure Events
 - Product or Device Events

Reno Behavioral Healthcare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 3 OF: 10
	EFFECTIVE: 02/2018
REVIEWED: 2/2019	REVISED: 2/2019

- Patient Protection Events
- Radiologic Events
- Care Management Events
- Environmental Events
- Potential Criminal Events
- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- Hospital Acquired Conditions (HACs):
 - a. Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, other injuries)
- The scope of the Patient Safety Plan encompasses the patient population, visitors, volunteers and staff (including medical staff). The plan addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:
 - Environment of Care
 - Emergency Management
 - Human Resources
 - Infection Prevention and Control
 - Information Management
 - Leadership
 - Life Safety
 - Medication Management

Reno Behavioral Healthcare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
	PAGE: 4
SECTION 06: LEADERSHIP	OF: 10
	EFFECTIVE: 02/2018
REVIEWED: 2/2019	REVISED: 2/2019

- Medical Staff
- Nursing
- Provision of Care, Treatment and Services
- Performance Improvement
- Record of Care, Treatment and Services
- Rights and Responsibilities of the Individual
- Waived Testing

Methodology:

- The Interdisciplinary Safety/Environment of Care Committee is responsible for the oversight of the Patient Safety Plan. The Safety/Environment of Care Committee Chairperson will have administrative responsibility for the plan, or the Safety/Environment of Care Committee may assign this responsibility to another member of the committee.
- All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Director PI/Risk Management, who will aggregate occurrence information and present a report to the Safety/Environment of Care Committee. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety/Environment of Care Committee will analyze the report information and determine further patient safety activities as appropriate.
- Through review of internal data reports and reports from external sources (including, but not limited to, sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the performance improvement priority criteria grid, the Safety/Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually. All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams). The proactive risk assessment will include:

Reno Behavioral Healthcare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
	PAGE: 5
SECTION 06: LEADERSHIP	OF: 10
	EFFECTIVE: 02/2018
REVIEWED: 2/2019	REVISED: 2/2019

- Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be
- Prioritizing the potential processes breakdowns or failures
 - For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
 - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
 - Test and implement the redesigned process
 - Identify and implement measures of the effectiveness of the redesigned process
 - Implement a strategy for maintaining the effectiveness of the redesigned process over time
- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organizationwide program.
- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:
 - Perform necessary healthcare interventions to protect and support the patient's clinical condition.
 - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others.
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.

Preserve any information related to the error (including physical information). Examples of preservation of medication label for medications administered to the incorrect patient.

Reno Behavioral Healthcare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
	PAGE: 6
SECTION 06: LEADERSHIP	OF: 10
	EFFECTIVE: 02/2018
REVIEWED: 2/2019	REVISED: 2/2019

Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.

- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the occurrence report to the Performance Improvement Department per organizational policy.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his/her supervisor and document the findings on an incident report. The report will be submitted to the Director PI/Risk Management per organizational policy.
- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:
 - No Harm Failures or Errors (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
 - Mild-Moderate Adverse Outcome Failures or Errors (including medication errors/variances) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the PI/Risk Management Department per organizational policy.
 - Medication Variances/errors - the staff member identifying a medication variance/error (no harm and mild-moderate harm) will notify the Pharmacy Department of the event.
 - Adverse Drug Reaction (ADR) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders.

Reno Behavioral Healthcare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 7 OF: 10
	EFFECTIVE: 02/2018
REVIEWED: 2/2019	REVISED: 2/2019

Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report, submitting the report to the PI/Risk Management Department. Staff will complete ADR report and forward to Pharmacy.

- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his/her supervisor and document the findings on an incident report. The report will be submitted to the PI/Risk Management Department per organizational policy.
- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.
- Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an incident report and submit the report to the PI/Risk Department.
- Hospital Acquired Conditions - staff will follow all established protocols, guidelines and policies and procedures. Staff shall complete incident reports for any breaks in technique or policy not followed.

Established organizational policy (such as the Sentinel Event Policy) and/or the Safety/Environment of Care Committee will determine the organizational response to process/system failures and/or medical/health care errors and occurrences. All sentinel events and near miss occurrences will have a root cause analysis conducted. The determination of the Safety/Environment of Care Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:

- Further remedial action activities necessary for identified occurrences
- Proactive occurrence reduction activities
- Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

Reno Behavioral Healthcare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 8 OF: 10
	EFFECTIVE: 02/2018
REVIEWED: 2/2019	REVISED: 2/2019

- An effective Patient Safety Plan cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences. All staff is required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Safety/Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.
- Sentinel Events - staff members involved in a sentinel event occurrence will receive support from the Safety/Environment of Care Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Safety/Environment of Care Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Service Department, Human Resources Department and/or his/her department supervisor.

As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to their accrediting organization. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting the safety or quality of care concern to their accrediting organization.

- On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.
- The Patient Safety Plan includes implementation of the recommendations set forth by the accrediting organization, or identified alternative recommendations defined by this institution, to achieve compliance with established safety standards. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified safety standards.

Reno Behavioral Healthcare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 9 OF: 10
	EFFECTIVE: 02/2018
REVIEWED: 2/2019	REVISED: 2/2019

- The Patient Safety Plan includes an annual survey of staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Safety/Environment of Care Committee will analyze error reporting data submitted through the PI/Risk Management Department for evidence of this information.

Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care.

The Patient Safety Plan includes consideration, at least annually, of data obtained from the organizational Information Management Needs Assessment, which includes information regarding barriers to effective communication among caregivers.

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. Education includes the staff member's right to report any safety or quality of care concerns to the organization's accrediting organization. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.
- Lessons learned from a root cause analysis shall be communicated to staff who provide services or are affected by a patient safety incident
- Patient safety reports from the Safety/Environment of Care Committee will be submitted to the organizational Quality, which exists as the oversight committee for the Safety/Environment of Care Committee. A data report and recordings of meeting minutes will be forwarded to the Quality Committee.

Reno Behavioral Healthcare Hospital	
SUBJECT: PATIENT SAFETY PLAN	POLICY #600.22
SECTION 06: LEADERSHIP	PAGE: 10 OF: 10
	EFFECTIVE: 02/2018
REVIEWED: 2/2019	REVISED: 2/2019

A written Patient Safety Report shall be forwarded to the Governing Body, at a minimum, once per year. Information in the report shall include:

- All system or process failures
- Number and type of sentinel events
- If patients and families were informed of the adverse events
- All actions taken to improve safety, both proactively and in response to actual occurrences
- All results of the analyses related to the adequacy of staffing and actions taken to resolve the identified problem(s)

Spring Valley Surgery Center LLC

2018 Sentinel event reporting

8828 Mohawk Street. Las Vegas NV 89139 License #: 8787

Safety committee:

The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the The Administration has established a “Life Safety Enterprise Safety Program” designed to keep patients, Physicians, employees and the public safe while on the premises of the Facility. This program consists of elements which meet the requirements as defined by the Federal, State, Local and OSHA guidelines. The “Safety Plan” includes identification, evaluation and prevention of workplace hazards relating to the elements and specific criteria. The safety management of the Facility is composed of several elements regarding the safety features necessary for the protection and security of its patients and healthcare workers.

These elements are composed of two parts; one “Life Safety Enterprise Safety Plan” which is wide in scope, organizational and effectiveness, and the “Environmental Safety Management” which oversees the working environment elements of the Facility. These areas overlap each other but also provide individual elements which manage the overall security and safety of the Facility. A report from the Safety Committee is provided quarterly to the Medical Executive Committee (MEC) and onto the Governing Board. The Safety Committee meets and discusses how to improve and/or maintain patient and employee well-being and safety, items discussed range from falls to how to properly lift boxes, and the execution of a disaster drills, etcetera. If any incidents have occurred they will be discussed in detail, and prevention and safety will be implemented.

Patient Safety Committee

Purpose To provide guidelines regarding authority and responsibilities of the Patient Safety Committee.

Responsibility Medical Director or designated LIP, Center Operations Manager, and other associates as assigned.

- Policy**
1. The Board of Directors and medical staff communicate to the Patient Safety Committee, acting through the Chairperson, the authority, accountability, and responsibility to institute any activities, studies, and control measures necessary to ensure the safe provision of healthcare activities to patients treated.
 2. The Patient Safety Committee is responsible for:
 - a. Overseeing the patient care activities
 - b. Planning, evaluation, and implementation of all matters relating to patient care
 - c. Review and approval of patient safety policies and procedures under the jurisdiction of the QAPI Team.
 3. The Patient Safety Committee shall meet at least quarterly.
 - a. This meeting is combined with the QAPI meeting.
 - b. The agenda for the meeting will consist of at least the following:
 - i. Old business
 - ii. Standing reports
 - iii. Adverse event review
 - iv. Sentinel event alerts
 - v. Regulatory updates
 - vi. New business
 - vii. Recommendations of consultants
 - viii. New literature
 - ix. Other
 4. The Patient Safety Committee will consist of a multidisciplinary team, but all facility staff are encouraged to attend:
 - a. Medical Director

DOCUMENT NUMBER				DOCUMENT REVISION #	DOCUMENT REVISION DATE	EFFECTIVE DATE
Main ID	ID #	Section	Scope			
PI	125	Performance Improvement	ALL	2	18-MAR-2013	12-DEC-2004
Patient Safety Committee						Page 1 of 2
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- b. Center Operations Manager / Administrator
- c. Registered Nurse (if COM is not a RN)
- d. Interventional Technologist (if COM is not a RT)
- e. Infection Prevention Assistant
- f. The following team members should be present where required and if applicable to that facility or as determined by state requirements.
 - i. Laboratory representative, if applicable
 - ii. Pharmacy Consultant, if and where applicable
 - iii. Property Manager / Physical Plant Engineer, if applicable
 - iv. Patient Safety Officer, where applicable
 - v. A community member, where applicable.

Minutes

1. Minutes shall be recorded and made available for all associates to review.
2. All associates are encouraged to attend and participate in the meetings.
3. The Center Operations Manager will utilize the template agenda and maintain meeting minutes on the template.
 - a. The meeting minutes shall include those who attended the meeting.
 - b. Those invited to the meeting.
4. Associates not present at the meeting are required to review the minutes and acknowledge review by date and signature.

DOCUMENT NUMBER				DOCUMENT REVISION #	DOCUMENT REVISION DATE	EFFECTIVE DATE
Main ID	ID #	Section	Scope			
PI	125	Performance Improvement	ALL	2	18-MAR-2013	12-DEC-2004
Patient Safety Committee						Page 2 of 2
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	Policy #:
SUBJECT/TITLE: Patient Safety Plan	PAGE 1 of 14
DEPARTMENT/SCOPE: Leadership	Owner: Administration

PURPOSE:

- The purpose of the organizational Patient Safety Plan at Elite Medical Center shall be to improve patient safety and reduce risk to patients through an environment that encourages:
 - Integration of safety priorities into all relevant organization processes, functions, services, departments and programs
 - Recognition and acknowledgment of risks to patient safety and medical/health care errors
 - The initiation of actions to reduce these risks
 - The internal and external reporting of what has been found and the actions taken
 - A focus on processes and systems, and the reduction of process and system failures through use of failure mode effect analysis
 - Minimization of individual blame or retribution for involvement in a medical/health care error
 - Organizational learning about medical/health care errors
 - Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations

- The Patient Safety Plan shall provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to potential or actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety shall involve multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Elite Medical Center. The Patient Safety Plan, developed by the interdisciplinary Safety/Environment of Care Committee and approved by the medical staff, Governing Body and administration, shall outline the components of the organizational Patient Safety Program.

	Policy #:
SUBJECT/TITLE: Patient Safety Plan	PAGE 2 of 14
DEPARTMENT/SCOPE: Leadership	Owner: Administration

PATIENT SAFETY PLAN:

- Scope of Activities:
 - The scope of the Patient Safety Plan shall include an ongoing proactive risk assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety.
 - One high-risk process shall be selected at least every 18 months and a proactive risk assessment shall be performed.
 - Patient safety occurrence information from aggregated data reports and individual incident occurrence reports shall be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:
 - No Harm - a patient safety event that reaches the patient but does not cause harm; those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
 - Close call - (or "near miss" or "good catch") is a patient safety event that did not reach the patient.
 - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
 - Any Medication Error
 - Any Adverse Drug Reaction
 - Any Transfusion Reaction
 - Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of an adverse event.

	Policy #:
SUBJECT/TITLE: Patient Safety Plan	PAGE 3 of 14
DEPARTMENT/SCOPE: Leadership	Owner: Administration

- Sentinel Event - A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following: death, permanent harm, severe temporary harm. Reporting must occur within 14 days to the Nevada Department of Health and behavioral Health
 - ◆ An event is also considered sentinel if it is one of the following:
 - Suicide of any patient in a setting where the patient receives around-the-clock care, or suicide of a patient within 72 hours of discharge, including from a hospital's Emergency Department
 - Unanticipated death of full term infant
 - Infant discharge to the wrong family
 - Abduction of any patient receiving care/services
 - Any elopement of a patient from a staffed around the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient
 - Assault, rape or homicide of a patient, staff member, LIP, visitor, vendor while at the hospital
 - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
 - Surgery or invasive procedure performed on the on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
 - The unintentional retention of a foreign object, i.e., sponge, instrument, in a postoperative or post-invasive procedure patient
 - Severe neonatal hyperbilirubinemia; bilirubin that is greater than 30 milligrams per deciliter
 - Prolonged fluoroscopy with cumulative dose greater than 1,500 rads to a single field, or any delivery of radiotherapy to the

wrong body region or greater than 25% above the prescribed radiotherapy dose

- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care
- Any intrapartum (related to the birth process) maternal death or severe maternal morbidity
- Hospital Acquired Conditions (HACs):
 - ◆ Foreign object retained after surgery
 - ◆ Air embolism
 - ◆ Blood incompatibility
 - ◆ Catheter-associated urinary tract infections
 - ◆ Pressure ulcers - Stages III and IV and unstageable
 - ◆ Vascular catheter-associated infection
 - ◆ Manifestations of poor glycemic control:
 - Diabetic ketoacidosis
 - Non-ketotic hyperosmolar coma
 - Hypoglycemic coma
 - Secondary diabetes with ketoacidosis
 - Secondary diabetes with hyperosmolarity
 - ◆ Surgical site infection - mediastinitis after coronary artery bypass graft surgery
 - ◆ Surgical site infections following bariatric surgery for obesity:

	Policy #:
SUBJECT/TITLE: Patient Safety Plan	PAGE 5 of 14
DEPARTMENT/SCOPE: Leadership	Owner: Administration

- Laparoscopic gastric bypass
 - Gastroenterostomy
 - Laparoscopic gastric restrictive surgery
 - ◆ Surgical site infections following certain orthopedic surgeries - spine, neck, shoulder, elbow
 - ◆ Deep vein thrombosis and pulmonary embolism following total knee replacement and hip replacement procedures
 - ◆ Surgical site infection following cardiac implantable electronic device (CIED)
 - ◆ Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, other injuries)
 - ◆ Iatrogenic pneumothorax with venous catheterization
 - ◆ Please check the CMS website for the most up-to-date list of preventable conditions (HACs)
- The scope of the Patient Safety Plan encompasses the patient population, visitors, volunteers and staff (including medical staff). The plan shall address maintenance and improvement in patient safety issues in every department throughout the facility. There shall be an emphasis on important hospital and patient care functions of:
 - Environment of Care
 - Emergency Management
 - Human Resources
 - Infection Prevention and Control
 - Information Management
 - Leadership



Policy #:

SUBJECT/TITLE: Patient Safety Plan

PAGE 6 of 14

DEPARTMENT/SCOPE: Leadership

Owner: Administration

- Life Safety
- Medication Management
- Medical Staff
- Nursing
- Provision of Care, Treatment and Services
- Performance Improvement
- Record of Care, Treatment and Services
- Rights and Responsibilities of the Individual
- Transplant Safety
- Waived Testing

	Policy #:
SUBJECT/TITLE: Patient Safety Plan	PAGE 7 of 14
DEPARTMENT/SCOPE: Leadership	Owner: Administration

- Methodology:

The Interdisciplinary Safety/Environment of Care Committee shall be responsible for the oversight of the Patient Safety Plan. The Safety/Environment of Care Committee Chairperson shall have administrative responsibility for the plan, or the Safety/Environment of Care Committee may assign this responsibility to another member of the committee

- All departments** within the organization (patient care and non-patient care departments) shall be responsible to report patient safety occurrences and potential occurrences to the Performance Improvement Committee will aggregate occurrence information and present a report to the Safety/Environment of Care Committee on a monthly basis. The report shall contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety/Environment of Care Committee shall analyze the report information and determine further patient safety activities as appropriate.
 - Through review of internal data reports and reports from external sources (including, but not limited to, The DNV, occurrence reporting information from state and federal sources and current literature), and through the performance improvement priority criteria grid, the Safety/Environment of Care Committee shall select at least one high-risk safety process for proactive risk assessment annually. All elements of the high-risk safety related process shall be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams). The proactive risk assessment shall include:
 - Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be
 - Prioritizing the potential processes breakdowns or failures
 - For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
 - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation

	Policy #:
SUBJECT/TITLE: Patient Safety Plan	PAGE 8 of 14
DEPARTMENT/SCOPE: Leadership	Owner: Administration

- Test and implement the redesigned process
 - Identify and implement measures of the effectiveness of the redesigned process
 - Implement a strategy for maintaining the effectiveness of the redesigned process over time
- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organization wide program.
- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:
 - Perform necessary healthcare interventions to protect and support the patient's clinical condition.
 - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
 - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
 - Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.

	Policy #:
	PAGE 9 of 14
SUBJECT/TITLE: Patient Safety Plan	Owner: Administration
DEPARTMENT/SCOPE: Leadership	

- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
 - Submit the occurrence report to the Performance Improvement Department per organizational policy.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue shall immediately notify his/her supervisor and document the findings on an occurrence report. The occurrence report shall be submitted to the Performance Improvement Department per organizational policy.
- Staff response to process/system failures and/or medical/health care errors shall be dependent upon the type of error identified:
 - No Harm Failures or Errors (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
 - Mild-Moderate Adverse Outcome Failures or Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Performance Improvement Department per organizational policy.
 - ◆ Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Department of the event.

	Policy #:
SUBJECT/TITLE: Patient Safety Plan	PAGE 10 of 14
DEPARTMENT/SCOPE: Leadership	Owner: Administration

- Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report, submitting the report to the Performance Improvement Department per organizational policy. Staff will also notify the Pharmacy Department.
 - Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his/her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Performance Improvement Department per organizational policy.
 - Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.
 - Close Call - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to the Performance Improvement Department.
 - Hospital Acquired Conditions - staff will follow all established protocols, guidelines and policies and procedures. Staff shall complete incident reports for any breaks in technique or policy not followed.
- Established organizational policy (such as the Sentinel Event Policy) and/or the Safety/Environment of Care Committee shall determine the organizational response to process/system failures and/or medical/health care errors and occurrences. All sentinel events and near miss occurrences shall have a root cause analysis conducted. The determination of the Safety/Environment of Care Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, shall determine:
 - Further remedial action activities necessary for identified occurrences
 - Proactive occurrence reduction activities

	Policy #:
SUBJECT/TITLE: Patient Safety Plan	PAGE 11 of 14
DEPARTMENT/SCOPE: Leadership	Owner: Administration

- Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities
- An effective Patient Safety Plan cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences; therefore, it shall be the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences. All staff shall be required to report suspected and identified medical/health care errors and should do so without the fear of reprisal in relationship to their employment. This organization shall support the concept that errors occur due to a breakdown in systems and processes, and shall focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus shall be placed on remedial actions to assist rather than punish staff members, with the Safety/Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.
 - Sentinel Events - staff members involved in a sentinel event occurrence shall receive support from the Safety/Environment of Care Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Safety/Environment of Care Committee shall encourage the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Service Department, Human Resources Department and/or his/her department supervisor.

	Policy #:
SUBJECT/TITLE: Patient Safety Plan	PAGE 12 of 14
DEPARTMENT/SCOPE: Leadership	Owner: Administration

- As part of this organization’s culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to their accrediting organization. The organization shall support the staff member’s right to report these concerns and shall take no disciplinary or retaliatory action against the staff member for reporting the safety or quality of care concern to their accrediting organization.
 - On at least an annual basis, staff shall be queried regarding their willingness to report medical/health care errors.
- The Patient Safety Plan shall include implementation of the recommendations set forth by the accrediting organization, or identified alternative recommendations defined by this institution, to achieve compliance with established safety standards. The selected recommendations shall be monitored on a routine basis to evaluate the organization’s effectiveness in the implementation of the recommendations in achieving compliance with the identified safety standards.
- The Patient Safety Plan shall include a quarterly survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.
- Patients, and when appropriate, their families shall be informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Safety/Environment of Care Committee shall request a report from the Business office manager on a quarterly basis consisting of random record review verifying compliance with informing the patient about outcomes of care. The Safety/Environment of Care Committee shall analyze error reporting data submitted through the Performance Improvement Department for evidence of this information.
- Staff shall educate patients and their families about their role in helping to facilitate the safe delivery of care. The Safety/Environment of Care Committee shall request a report from the business office manager on a quarterly basis consisting of random record review verifying compliance with this educational process.

	Policy #:
SUBJECT/TITLE: Patient Safety Plan	PAGE 13 of 14
DEPARTMENT/SCOPE: Leadership	Owner: Administration

- The Patient Safety Plan shall include consideration, at least annually, of data obtained from the organizational Information Management Needs Assessment, which includes information regarding barriers to effective communication among caregivers. The Safety/Environment of Care Committee shall also request on a quarterly basis, a report from the Business office manager identifying the effectiveness of the organization to provide accurate, timely, and complete verbal and written communication among care givers and all other involved in the utilization of data.
- Staff shall receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. Education shall include the staff member’s right to report any safety or quality of care concerns to the organization’s accrediting organization. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff shall be educated and trained on the provision of an interdisciplinary approach to patient care.
- Medical/health care errors and occurrences, including sentinel events, shall be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting shall be performed in accordance with all state, federal and regulatory body rules, laws and requirements.
- Lessons learned from a root cause analysis shall be communicated to staff who provide services or are affected by a patient safety incident. Education shall take place through the Education Department.
- Patient safety reports from the Safety/Environment of Care Committee shall be submitted to the organizational Performance Improvement Committee, which exists as the oversight committee for the Safety/Environment of Care Committee. A monthly data report and recordings of meeting minutes shall be forwarded to the Performance Improvement Committee, with all information submitted held under the auspices of the Performance Improvement Committee.

	Policy #:
SUBJECT/TITLE: Patient Safety Plan	PAGE 14 of 14
DEPARTMENT/SCOPE: Leadership	Owner: Administration

- A written Patient Safety Report shall be forwarded to the Governing Body, at a minimum, once per year. Information in the report shall include:
 - All system or process failures
 - Number and type of sentinel events
 - If patients and families were informed of the adverse events
 - All actions taken to improve safety, both proactively and in response to actual occurrences
 - All results of the analyses related to the adequacy of staffing and actions taken to resolve the identified problem(s)

REFERENCE:

Centers for Medicare and Medicaid Services (CMS), Medicare, Hospital-Acquired Conditions (Present on Admission Indicator), *Hospital-Acquired Conditions*, page last modified 08/19/2015, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

2019 Patient Safety Plan

Introduction

CrowdRx is committed to a culture of safety consistent with our mission and core values. Our commitment to clinical excellence ensures that patients are provided with acute medical care in a discreet and caring environment, regardless of the location. We deliver medical attention with compliance and compassion to create a service where clinical excellence is the outcome and happy customers are the benefit.

Purpose

The Patient Safety Plan provides a planned, systematic, coordinated approach for continually improving the health and safety of patients who are treated at the medical facility, by reducing patient harm and maintaining a safety culture.

The Patient Safety Plan includes:

- Establishment of a Patient Safety Committee:
 - o Membership to include:
 - Patient Safety Officer
 - Infection Control Officer
 - At least three (3) providers of health care who treat patients at the medical facility, including one medical, nursing, and pharmaceutical staff
 - Executive Officer
 - o Per approval from the Sentinel Event Registrar, the Patient Safety Committee shall meet twice annually.
- An Infection Control Program to prevent and control infections within the medical facility (this is a document separate from the Patient Safety Plan that meets the requirements for NRS 439.865)
- Adoption of Patient Safety checklists and patient safety policies as required by NRS 439.877
 - o Adoption of patient safety checklists and policies
 - o Annual review and revision of checklists and policies
 - o Annual Report to Sentinel Event Registrar
- Integration of all patient safety activities both ongoing and developing
- Ongoing orientation, education, and training to emphasize specific job related aspects of patient safety to maintain and improve staff awareness
- Encourage internal reporting of medical/healthcare incidents and events, effectively respond to actual occurrences, manage occurrences, and events with a non-punitive approach, and focus on processes and systems to minimize individual blame and retribution

- Periodic survey of the staff regarding willingness to report, actions taken and outcomes of occurrences and events
- Internal reporting of findings, actions taken and resolution, organizational learning and communication of occurrence and event information
- Consideration of patient safety priorities when designing and redesigning of relevant processes, functions, and services
- Involvement and education of patients and their families about their role in facilitating safe delivery of care, identifying potential risks and suggesting improvement to patient safety

Scope of Activities

The Patient Safety Committee integrates all components of safety into the organization wide safety program by collaboration among the following, but not limited to Quality, Environmental Safety, Infection Control, Patient Care areas, Risk Management, Compliance, and Ethics.

Patient Safety Committee activities include:

- Receive and review investigative reports from the Patient Safety Officer regarding Sentinel events alleged to have occurred, and actions taken to ensure the safety of patients resulting from Sentinel Events reported to State of Nevada Pursuant to NRS Chapter 439
- Make recommendations to the executive body to reduce the number and severity of sentinel events and infections that occur
- Provide emotional support for staff involved in incidents or events, as appropriate
- Report at least quarterly to the executive body:
 - o The number of sentinel events that occurred the previous quarter
 - o The number and severity of infections that occurred the previous quarter
- Review and evaluate the quality measures carried out by the medical facility to improve the safety of the patients who have received treatment
- Review and evaluate the quality measures carried out by the medical facility to prevent infections
- Monitor patient and environmental safety issues identified throughout the organization
- Promote the use of internal and external knowledge and experience to prevent patient harm, events and occurrences, and to maintain and improve patient safety and prevent unsafe occurrences
- Review aggregated or trended data: No Harm events, Mild or moderate adverse outcomes, Near miss, Medication events, Adverse drug reactions, Transfusion reactions, Hazardous conditions, Present on admission, Clinic acquired conditions, or Online incident reports, utilizing a proactive approach

to recognize and acknowledge medical/healthcare events and risks to patient safety, to make recommendations and initiate actions to reduce those events and risks

- Prioritize and recommend Patient Safety activities, as appropriate.
 - o Types of Environmental Safety data/activities that may be review, aggregated, or trended may include: Security, Employee Safety/Job Related Injuries, Emergency Preparedness, Lab or Radiation Safety, Utilities Management, Bio Med or Fire Drill Inspections

Patient Safety Officer

The Patient Safety Officer is designated by the medical facility and has administrative responsibilities as prescribed by NRS chapter 439 (specifically outlined in NRS 439.815 through NRS 439.875) and by other regulatory agencies and accrediting bodies. Duties and responsibilities include but are not limited to”

- Serving on the Patient Safety Committee
- Supervising sentinel event reporting to the State
- Conducting mandatory investigations,, developing and implementing action plans
- Ensuring notification as appropriate within the medical facility

Structure

The Quality Reporting Structure Model (Attachment B) visually diagrams the reporting structure.

Checklist Title	Checklist Category
Discharge Checklist	Discharge
Fire Drill Participation	Environmental Safety
Rampart Cleaning Checklist	Housekeeping
Crash Cart Checklist	Treatment
Routine Venipuncture Guidelines	Treatment
Lab Personnel Training and Competency Checklist	Training
Lab Safety Policies Checklist	Laboratory
AED Checklist	Other Safety
Temperature Log	Environmental
Urine Dipstick Quality Control Log	Laboratory
Blood Glucometry Quality Control Log	Laboratory
Urine Pregnancy Quality Control Log	Laboratory
Specimen Labeling Requirements	Laboratory
iStat Quality Control Log	Laboratory
LTV 1200 Ventilator Reference Guide	Clinical
Fire Extinguisher Inspection Log	Environmental Safety
Positive Patient Identification Checklist	Clinical

MEDICAL AND DENTAL CENTER OF NEVADA

Patient Safety Checklist

ADMISSION/REGISTRATION *(Check all that apply)*

- Patient Identified using two (2) identifiers
- Surgical consent reviewed for accuracy and signed. If not, why? _____
- Responsible transportation verified
- Advance Directives addressed
- Allergies noted with RED allergy armband (if applicable)

Signed: _____ Time: _____

PRE-OP *(Check all that apply)*

- Patient identified using two (2) identifiers
- Surgical consent reviewed with patient
- Pre-Assessment completed and notable patient history items are reported to OR circulator
- H & P is present/complete prior to departure for surgery
- Patient is involved in appropriate Surgical Site Marking (if applicable)
- Labs, EKG, and other study documents are placed in chart
- Hand hygiene is followed before and after patient care
- Antibiotic prophylaxis, pre-op medical orders are administered as ordered -OR- N/A
- Allergies are confirmed with patient
- Stretcher is locked & siderails are in up position during waiting periods

Signed: _____ Time: _____

OPERATING ROOM *(Check all that apply)*

- Patient identified using two (2) identifiers
- Surgical consent reviewed with patient
- Obtained Report from Pre-Op Nurse, including allergies, and report of pertinent medical issues
- Required documents are present in chart prior to departure to OR (H&P, Labs, Consent, Pre-Op assessment, etc.)
- Patient visited by Surgeon, Anesthesia, and all questions answered
- OR is prepared appropriately with proper equipment (anesthesia, suction, safety belts, SCD, instrumentation, implants, video equipment, emergency cart, and any other appropriate equipment, as indicated for planned procedure.
- Site Mark is completed by Physician's Initials with single use skin marker
- SHSC Time-Out Protocol is followed prior to incision
- Hand hygiene is followed before and after patient care
- Vendors or other Contracted Patient Care Providers maintain all applicable safety standards as indicated within the SHSC visitor/vendor policy
- Additional Staff are available for induction/emergence if indicated
- All available safety equipment is used as indicated (belts, safety straps, tape, padding, gel pads, positioning aides, grounding pad)
- Upon arrival to PACU, appropriate hand-off communication/reporting is utilized

Signed: _____ Time: _____

Medical and Dental Center of Nevada

Chapter Name: 7 - Infection Prevention and Control and Safety	Policy#: 7.01	AAHC Standard: 7I
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Title:
Surveillance, Prevention, and Control of Infection

Date: Date Revised:

POLICY:

- The Infection Control Officer (**ICO**) as part of the Quality Assurance Performance Improvement Committee (**QAPIC**) oversees the Infection Control Program (**ICP**). The QAPIC is multi-dimensional and includes components of surveillance, epidemiology, consultation, and education and performance improvement.
- The QAPIC is a multi-dimensional committee consisting of members of the medical staff, Director of Nursing, and clinical staff. Regularly scheduled meetings will be held quarterly or as needed to discuss issues that need to be addressed on an urgent basis.
- Infection control risk assessment, surveillance and prevention activities are designed to coordinate infection control process with the relevant patient care support departments/services (i.e. medical staff, employee health, safety, environmental, materials management, nursing education and Clark County health department).
- Risk prevention:
The QAPI committee selected the following surveillance indicators for 2018 based on a prioritized risk assessment;
 - ✓ Post-operative surgical wound infections
 - ✓ Prevention: Blood borne pathogens exposure and priority risk assessment with sharps safety and post-exposure follow-up
 - ✓ Monthly monitoring of sterile processing logs/outcomes and compliance
 - ✓ Prioritized risk assessment based on MDCNV specialties
- All clinical employees at MDCNV are included in the Infection Control Program. The primary method of surveillance will be targeted as determined by QAPIC's review of priorities using the risk assessment process.
- The IC Program is based nationally-recognized guidelines regarding infection prevention and control, including CDC, APIC, and OSHA.
- The Infection Control Program is approved by the Governing Body and annually reviewed/updated, and approved.

Medical and Dental Center of Nevada

PROCEDURE:

Surgical Patients / Post-Operative Infections:

MDCNV performs call backs to all patients following their procedure, to be done within 48-72 hours. The call is to include the reporting of symptoms of surgical site infection based on guidelines set forth by the facility. If a patient reports signs or symptoms of a post-operative infection, it is noted and the operating physician is immediately notified. The process of identifying the cause is started.

Infections are identified by monthly infection control reports which are sent to each physician that performed cases the previous month. It is required that this report is completed and returned to MDCNV within the month it was issued to them. All reports are reviewed by the IC Nurse or his/her designee. It is expected that if a physician notes a post-operative infection that he/she believes may be related to the center, that he/she immediately notify the Director of Nursing. If an infection is noted on the returned report, an investigation is immediately started.

Data is collected, analyzed and trended with a report submitted to the QAPI committee quarterly or as needed.

Blood borne Exposure/Follow-Up:

All blood borne exposures are to be reported immediately on occurrence, per the Exposure Control Plan, to the Director of Nursing. The exposed are treated per the established protocol, all information is documented appropriately. All Exposures are tracked and reported per OSHA guidelines. All staff involved with an exposure is asked to provide information for the future prevention of such incidences. All information is reported to the CQAPI committee and the GB for evaluation and possible alteration of practices or processes in the future.

Reports are trended and tracked in order to determine potential issues with a provider, a specialty, a procedure type, piece of equipment, etc...

Safe injection practices will be strictly adhered to at the facility to minimize and prevent blood borne pathogen exposure to patients and staff. This includes sharps safety. Staff will be routinely educated and monitored for compliance in injection practices and sharps safety.

Monthly Monitoring of sterile processing:

Logs are monitored to ensure that all calibrations, biologicals, etc...are within the normal limits for the particular system; based on manufacturer guidelines. This is documented on a sterilizer monitoring and maintenance logs.

Goals for the Infection Control Program:

- To identify and reduce the risk of endemic and epidemic facility-associated infection in patients, associates, physicians, others providing direct patient care, contract service workers, students and visitors. **Endemic**-the habitual presence of an infection within a geographical area. It may also refer to the usual prevalence of a

Medical and Dental Center of Nevada

given disease within such an area. **Epidemic**-An outbreak in the community or region of a group of infections of a similar nature, clearly in excess of normal expectancy and derived from a common or propagated source.

- To establish specific goals on a systemic risk analysis. The risk analysis shall be completed on healthcare elements that are: high volume, frequent infectious complications, high potential for adverse complications, and substantial potential for prevention/control. The analysis will guide the CQAPI committee in prioritizing and developing strategies to minimize, reduce, and eliminate the identified potential risk.
- To report appropriate information to the organization and public health authorities.
- To develop communication linkage between professional and healthcare workers, patients, families, public health professionals and the community.
- To develop plans that respond to emerging infections and bioterrorism.
- To promote zero tolerance of healthcare associated infections.
- To promote professional growth and leadership.

The Medical Director has been granted authority to take immediate action to prevent and control infections.

Under the direction of the Medical Director the Director of Nursing and IC Nurse investigates all suspected outbreaks. This is done in collaboration with appropriate medical and administrative staff. Appropriate corrective actions are made and findings are documented and reported to the QAPI committee.

The Governing Body approves the types and scopes of surveillance activities. These activities minimally include:

- The quality indicators for each year
- The methods to collect data on the indicators

Definitions of infections are based on CDC/NNIS guidelines.

The Director of Nursing and/or IC Nurse collects data in the following ways:

- Makes rounds in each department, observing staff and procedures.
- Reviews all infectious disease testing to be sent to reference lab.
- Receives information from physicians, physicians office staff, other facilities, etc...
- Targeted post discharge surveillance (call back process).
- Hand hygiene surveillance.
- Review open and closed medical records.
- Confers with nursing personnel.
- Receives notification by other medical centers, Nevada Department of Health, Clark County Health Department and other medical entities.
- Communicates with receiving hospital once aware that a transferred patient has an active infection for which treatment should start or change, or that the receiving hospital identifies as infection not identified by MDCNV (such as an infected wound).
- The Director of Nursing and/or IC Nurse promptly reports diseases that are reportable to the Clark County Health Department.

Medical and Dental Center of Nevada

The Director of Nursing develops and maintains and Infection Control Policy and Procedure Plan and Blood borne Pathogens Prevention Plan. All policies are based on current published literature.

The Director of Nursing develops and conducts infection control training with the orientation program for new employees and annual training for ongoing infection control compliance.

Strategies:

- CDC, AAAHC, OSHA regulations, and pertinent federal, state and local regulations pertaining to infection control are implemented and followed.
- Patient care services include: Entire facility
- Needs and risk factors of patients include a patient population at risk of acquiring infections.
- Alcohol based gel dispensers are strategically placed throughout the facility, as recommended by the CDC.
- In service education is provided to all employees with particular emphasis on:
 - ✓ Proper use of personal protective equipment (PPE's) for staff at risk of accidental exposure to blood and/or body fluids.
 - ✓ Tuberculosis (TB), its mode of transmission and the TB Policy.
 - ✓ Hand hygiene in compliance with current CDC guidelines.
- Training is provided to employees related to the appropriate storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment within 10 days of hire and annually thereafter.
- Surveillance will include nosocomial infections among patients.
- Departmental policies and procedures for infection control will be reviewed and/or revised as an ongoing practice.
- Medical waste management and disposal will be reviewed and/revised as needed.
- Interaction with mandatory reporting to Clark County Health Department and Nevada Department of Health will be carried out.
- Implementation of applicable infection control precautions as appropriate will be based on the following:
 - ✓ The potential for transmission
 - ✓ The mechanism for transmission
 - ✓ The care, treatment and service setting
 - ✓ The emergence and re-emergence of pathogens in the community that could affect the surgery center.

Effectiveness of the IC Program:

- MDCNV formally evaluates and revises the goals and the program (or portions of the program) at least annually and whenever risks are significantly changed.
- The evaluation addresses and changes in the scope of the IC program (i.e. from the introduction of new services).
- The evaluation addresses changes in the results of the IC program risk analysis.
- The evaluation addresses the assessment of the success or failure of interventions for preventing and controlling infections.
- The evaluation addresses responses to concerns raised by leadership and others within MDCNV.

Medical and Dental Center of Nevada

- The evaluation addresses the evolution of relevant infection prevention and control guidelines that are based on evidence or in the absence of evidence, expert consensus.

Who Should Know this Policy:

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> All Employees | <input type="checkbox"/> All Clinical Staff | <input type="checkbox"/> All Medical Staff |
| <input type="checkbox"/> OR Staff | <input type="checkbox"/> Pre-Op Staff | <input type="checkbox"/> Post-Op Staff |
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Medical Director | <input type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> All Business Office Staff | <input type="checkbox"/> Business Office Manager | |