

# ***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 ANNULLY 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 INIATING TREATMENT AT THE CENTER.
5. MONTORING AND EVALUTION 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, FACITITY OPERATIONS COMMITTEE, AND THE MEDICAL EXCUTIVE 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 THE TRANMITTAL 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.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

SECTION: N SAFETY

DATE: 11/97, 3/09, 11/11, 1/13

### **TITLE: N-20 CRASH CART CONTENTS**

#### **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

DATE: 11/97, 3/09, 11/11, 1/13

### **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)

SECTION: N SAFETY

DATE: 11/97, 3/09, 11/11, 1/13

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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
  - Senn Retractors
  - Knife handle
  - Needle Holder
  - Suture Scissor
  - Kelly Clamp
  - Betadine
  - Gauze 4x4
  - Lubricant



# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

SECTION: N SAFETY

DATE: 11/97, 3/09, 11/11, 1/13

**TITLE: N-20 CRASH CART CONTENTS**

### **DRAWER 5**

- **MALIGNANT HYPERTHERMIA**
  - Dantrium Intravenous 20mg (18)
  - Sterile Water for Reconstitution (500 cc X 3)
  - 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)
  - Arterial Blood Sample Syringes (2)

### **MALIGNANT HYPERTHERMIA SUPPLIES – NOT IN CRASH CART**

#### **ITEM**

Cubed Ice  
Freeze Packs  
NACL Pour Bottles (1000 cc X 2)  
Lactated Ringer's I.V. (1000 cc X 2)  
Insulin Humulin R (1)

#### **LOCATION**

Staff Lounge Freezer  
Refreshment Refrigerator, Recovery Room  
Medication Refrigerator, Nursing Station  
Medication Refrigerator, Nursing Station  
Medication Refrigerator, Nursing Station

SECTION: N SAFETY

DATE 11/97, 7/03, 9/14  
REVIEWED: 3/12

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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:
  - 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 BUTTON
  - 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.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

REVIEWED: 3/12

### **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.

SECTION: N SAFETY

DATE: 11/97, 9/99, 7/03  
REVIEWED: 3/12

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

**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.
2. SUPPLIES REQUIRING REFRIGERATION ARE STORED IN THE MEDICATION REFRIGERATOR AT THE NURSES STATION.
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 A INPATIENT FACILITY.

### **SYMPTOMS TO OBSERVE FOR MALIGNANT HYPERTHERMIA**

- \*\*INTENSE MUSCLE RIGIDITY(USUALLY MASSETER MUSCLE FIRST)  
CAN INVOLVE ENTIRE BODY.
- \*\*RAPID INCREASE IN END TIDAL CO<sub>2</sub>
- \*\*RAPID DECREASE IN OXYGEN SATURATION
- \*\*SUDDEN UNEXPLAINED TACHYCARDIA.
- \*\*TACHYPNEA
- \*\*UNSTABLE BLOOD PRESSURE
- \*\*ARRHYTHMIAS
- \*\*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
- \*\*HYPERKALEMIA
- \*\*MYOGLOBINEMIA
- \*\*ELEVATED CPK

4. FOLLOWING THE SUSPECTED DIAGNOSIS OF MALIGNANT HYPERTHERMIA, THE ANES-  
THESIOLOGIST WILL STOP ANESTHESIA.

SECTION: N SAFETY

DATE: 11/97, 9/99, 7/03  
REVIEWED: 3/12

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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 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, MG, COAG STUDIES, URINE FROM INITIAL FOLEY INSERTION FOR MYOGLOBIN.
  - B. TRANSFER ARRANGEMENTS TO HOSPITAL OF THE PHYSICIAN'S CHOICE.
  - C. AMBULANCE ARRANGEMENTS

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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:

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

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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 PACU 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 PROPER CRITIQUE FORM AND M.H. 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 (18)
- Sterile Water for Reconstitution (1000 cc X 3)
- IV Administration Set (2)
- 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)

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

**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)	Refreshment Refrigerator, Recovery Room
NACL Pour Bottles	Medication Refrigerator, Recovery Room
(1000 cc X 4)	
Lactated Ringer's I.V.	Medication Refrigerator, Recovery Room
(1000 cc X 4)	
Insulin (Humulin R)	Medication Refrigerator, Recovery RoOM

**STAT LAB WORK**

\*\*\*\*\*BLACK / RED TUBES X 2: CPK, LDH, ELECTROLYTES (NA, K, CL, CA, MG )

\*\*\*\*\*BLUE TUBE: PT (COAGULATION)

\*\*\*\*\*YELLOW URINE: URINE FOR MYOGLOBIN

\*\*\*\*\*BLOOD GAS KIT

**SECTION: N SAFETY**

**DATE: 11/97, 7/03, 3/10**

**8/12, 11/13**



# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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 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:

**SECTION: N SAFETY**

**DATE: 11/97, 7/03, 3/10  
8/12, 11/13**

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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.
- AIRWAY EQUIPMENT-SOME RESUSCITATION BAGS, FACE MASKS AND NASAL AIRWAYS CONTAIN LATEX.
- IV EQUIPMENT-LATEX TOURNIQUETS ARE OFTEN USED TO START AN IV.

CATHETERS AND ENTERAL TUBING-SUCH AS INDWELLING URINARY

CATHETERS OR NASO-GASTRIC TUBES MAY BE MADE WITH 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.

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.

SECTION: N SAFETY

DATE: 11/97, 7/03, 3/10  
8/12, 11/13

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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.

#### **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.

SECTION: N SAFETY

DATE: 11/97, 7/03, 3/10  
8/12, 11/13

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

**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

**SECTION: N SAFETY**

**DATE: 11/97, 7/03, 2/13,  
3/12**

**TITLE: N-55 CODE BLUE ANNOUNCEMENT**

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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.
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

DATE: 11/97, 7/03, 9/09

REVIEWED: 3/12

**TITLE: N-60 DEVICE TRACKING**

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

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 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
- MESH (MARLEX, PROLENE, SURGIPRO, GORETEX, ETC.)
- MOLTENO IMPLANTS
- PLATES
- SPINAL CORD STIMULATORS (PERMANENT)
- TOE IMPLANTS

2. WHEN AN IMPLANT IS RECEIVED, IT WILL BE DOCUMENTED IN THE  
PURCHASING COMPUTER SYSTEM AND THEN PUT IN THE OPERATING ROOM  
INVENTORY.

3. 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 BOX. IMPLANT INFORMATION IS MARKED RIGHT OR LEFT FOR  
MAMMARY PROSTHESIS. THE CIRCULATING NURSE WILL SEND THE  
APPROPRIATE REGISTRATION FORMS TO THE MANUFACTURER.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

4. 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  
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

**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

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

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 CONTAMINATED CLOTHING AND EQUIPMENT.

SECTION: N SAFETY

DATE: 11/97, 8/98, 7/03  
REVIEWED: 3/12

**TITLE: N-70 PROTECTION AGAINST OCCUPATIONAL EXPOSURE TO INFECTIOUS DISEASES**



# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- 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.
- 2) FOR MUCOUS MEMBRANE EXPOSURE: EYE SHIELDS, MASKS.
- 3) FOR CLOTHING EXPOSURE: APRONS OR GOWNS.

SECTION: N SAFETY

DATE: 11/97, 8/98, 7/03  
REVIEWED: 3/12

**TITLE: N-70 PROTECTION AGAINST OCCUPATIONAL EXPOSURE TO INFECTIOUS DISEASES**

CATEGORY II: TASKS THAT INVOLVE NO EXPOSURE TO

# **WILDCREEK SURGERY CENTER**

## **POLICIES AND PROCEDURES**

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  
SCRUB NURSES  
SCRUB TECHNICIANS  
INSTRUMENT TECHS  
ANESTHESIA AIDES  
PRE-OP NURSES  
PACU NURSES

#### **CATEGORY II:**

LAUNDRY PERSONNEL  
HOUSEKEEPING

#### **CATEGORY III:**

ADMITTING CLERK  
RECEPTIONIST  
BILLING CLERK  
INSURANCE CLERK  
MEDICAL RECORDS CLERK  
SCHEDULING CLERK

SECTION: N SAFETY

DATE: 11/97, 8/98, 7/03  
REVIEWED: 3/12

**TITLE: N-70 PROTECTION AGAINST OCCUPATIONAL EXPOSURE TO INFECTIOUS DISEASES**

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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:** ALL PERSONNEL PERFORMING CATEGORY II TASKS WILL HAVE 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 ASSISTING THE PATIENT TO DRESS DOES NOT REQUIRE PROTECTIVE CLOTHING AND EQUIPMENT.
- CATEGORY III:** NO SPECIAL PROTECTIVE CLOTHING OR EQUIPMENT IS REQUIRED FOR CATEGORY III TASKS. IF A TASK REQUIRES CATEGORY I OR II EXPOSURE, THE APPROPRIATE PERSONNEL WILL BE CALLED TO PERFORM THE TASK.

SECTION: N SAFETY

DATE: 11/97, 7/03, 9/04  
REVIEWED: 3/12

**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

# **WILDCREEK SURGERY CENTER**

## **POLICIES AND PROCEDURES**

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.
- 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.

SECTION: N SAFETY

DATE: 11/97, 7/03, 9/04

REVIEWED: 3/12

**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

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

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 CONDITIONING 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

DATE: 11/97, 7/03

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 incure job-related injury or illness, and will establish the time when the employee may safely resume their job.

# **WILDCREEK SURGERY CENTER**

## **POLICIES AND PROCEDURES**

### **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 Physician 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.

SECTION: n safety

DATE: 11/97, 7/03  
reviewed: 3/12

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

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

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.

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



# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

such as an eye examination, hearing test, or a complete physical exam, or educational counseling to eliminate future accidents.

SECTION: n safety

DATE: 11/97, 7/03

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.

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.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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.

**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 ESCEEDS**

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

SECTION: N SAFETY

DATE: 10/10, 8/13

REVIEWED: 7/14

**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.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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:**

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

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

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 **AAAH** 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:**

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.

**Subject: VIII - Patient Safety Plan****I. PURPOSE:**

The purpose of the Patient Safety Plan is to outline the process for implementing a patient safety program at 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 Western Nevada Surgical Center to promote the reduction of risks to patients through an integrated and coordinated organization-wide approach. The 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:**

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
  - Improve the accuracy of patient identification
  - Improve the effectiveness of communication among caregivers
  - Improve the safety of using high-alert medications
  - Eliminate wrong-site, wrong-patient and wrong-procedure surgery
  - Improve the effectiveness of clinical alarm systems

**IV. AUTHORITY & RESPONSIBILITY:**

- A. Governing Body – The Governing Body of WNSC has the ultimate responsibility for patient safety. To fulfill the commitment to patient safety, the board delegates

Subject: **VIII - Patient Safety Plan**

the responsibility for identifying, analyzing and managing patient safety activities to administration, management, supervisors, medical staff and employees. The 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 Governing Body provides direction for the organization's improvement activities. Reports from the Utilization Review/Quality Improvement Committee provide the Board with a means of evaluating the organization's effectiveness in reducing risks to patient safety.

- 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 the Utilization/Quality Improvement Committee..

**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.
- 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 Administrator. The Administrator is then responsible for notifying the appropriate organizational leaders .

**Subject: VIII - Patient Safety Plan**

- E. When a medical/health care error or near miss occurs, a staff member involved in the occurrence will complete an Incident Report and Follow-Up.
- F. The 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 the Administrator.
- 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.
- H. 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 error. The Administrator will discuss the details of each case with appropriate staff to determine what authorities need to be notified.
- I. Data related to medical/health care errors 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 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.



<h1>MICOE</h1>	<b>MINIMALLY INVASIVE CENTER OF EXCELLENCE</b>	
	<small>ORIGINAL DATE:</small> January 2013	<small>REVISED DATE:</small> 
	<small>PAGE NUMBER:</small> 1 of 2	
<small>POLICY NUMBER:</small> 7-14	<small>SUBJECT:</small> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">ADVERSE INCIDENTS</div>	
<small>NURSE MANAGER:</small> Name has been removed base on NRS439.843.		

## PURPOSE:

To provide a protocol for establishing a process that identifies, analyzes reports and prevents adverse incidents from potentially occurring at the surgery center.

## DEFINITION:

An adverse incident is defined as:

1. An unexpected occurrence during a surgical procedure or other health care encounter that results in a 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.
2. Any variation in the process of the functions of the surgical center that has the potential to cause a recurrence of a serious adverse outcome.
3. Events either in administration or elsewhere that causes either a breach in the medical care or other breaches resulting in a negative impact on a patient, even where death or loss of limb or function does not occur.

## POLICY:

1. Any incident that is defined, as an adverse incident shall be recorded immediately in the Adverse Outcomes Log Book under the appropriate section, as the incident deems. It will be the responsibility of administration to ensure that the person completing the report documents the incident as complete and accurate as possible. The report shall be reviewed by the administration of the surgery center no later than 24-hours after the incident, and then it will be forwarded to the appropriate channels.
2. Any incident that is defined as an adverse incident that occurs at the center will be reviewed by the members of the Quality Assurance Committee that are responsible for the Risk Management of the facility.

<b>MICOE</b>	<b>MINIMALLY INVASIVE CENTER OF EXCELLENCE</b>		
	ORIGINAL DATE:	REVISED DATE:	PAGE NUMBER:
	January 2013		2 of 2
	SUBJECT:		NURSE MANAGER:
	<b>ADVERSE INCIDENTS</b>		MEDICAL DIRECTOR:
POLICY NUMBER:			Name has been removed base on NRS439.843.
7-14			

3. The Quality Assurance Committee shall conduct a thorough analysis when an adverse incident occurs in order to identify the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an adverse incident.
4. The analysis shall also identify potential improvements in the processes or systems that would tend to decrease the likelihood of such incidents in the future, or determines, after analysis, that no such improvement opportunities exist.
5. Upon completion of the Quality Assurance Committee analysis they shall forward the information to the Governing Body. Upon a complete review by the members of the Governing Body it will be determined is any additional measures need to be taken, including that of notification to external agencies in accordance with accreditation regulations or local and federal law.
6. The members of the Governing Body along with the assistance of the Quality Assurance Committee, as necessary, shall formulate an action plan that identifies the strategies that the surgery center intends to implement to reduce the risk of similar incidents occurring in the future.
7. The plan will address:
  - a. Who is responsible for the implementation,
  - b. Oversight,
  - c. Testing as appropriate,
  - d. Time lines, and
  - e. Strategies for measuring the effectiveness of the actions taken.

# **WARM SPRINGS SURGERY CENTER**

## **PATIENT SAFETY PLAN**

### **PURPOSE**

The Warm Springs Surgery Center Patient Safety Plan is designed to improve patient safety, reduce risk and respect the dignity of those we serve by assuring a safe environment. Recognizing that effective medical/health care error reduction requires an integrated and coordinated approach, the following plan relates specifically to a systematic center-wide program to minimize physical injury, accidents and undue psychological stress during a patient's stay at Warm Springs Surgery Center. The center-wide safety program will include all activities contributing to the maintenance and improvement of patient safety.

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 an environment through their personal example; emphasizing patient safety as an organizational priority; providing education to medical and center staff regarding the commitment to reduction of medical errors; supporting proactive reduction in medical/health care errors; and integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

### **OBJECTIVES**

The objectives of the Patient Safety Plan are to:

- Encourage organizational learning about medical/health care errors
- Incorporate recognition of patient safety as an integral job responsibility
- Provide education of 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.

### **ORGANIZATION AND FUNCTIONS**

The Patient Safety Team is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The Team will meet quarterly to assure the maintenance and improvement of Patient Safety in establishment of plans, processes and mechanisms involved in the provision of the patient care.

- A. The scope of the Patient Safety Team includes medical/healthcare errors involving the patient population of all ages, visitors, staff, students and volunteers. The severity categories of medical/health care errors include:
- No Harm Error – an unintended act, either of omission or commission, or an act that does not achieve its intended outcome
  - Mild to Moderate Adverse Outcome – any set of circumstances that do not achieve the desired outcome and result in an mild to moderate physical or psychological adverse patient outcome
  - 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
  - Sentinel Event – 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
- B. The Patient Safety Team will be chaired by the designated Patient Safety Officer.
1. The responsibilities of the Patient Safety Officer include compliance with patient safety standards and initiatives, evaluation of work performance as it relates to patient safety, reinforcement of the expectations of the Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.
- C. As this organization 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 into the root cause analysis for educational purposes and prevention of further occurrences.
  - Annual staff surveys about their willingness to report medical errors
- D. As a member of an integrated healthcare system and in cooperation with system initiatives, the following Patient Safety Measures will be the focus of Patient Safety activities:
1. Adverse Drug Events
  2. Nosocomial/Post-operative Infections
  3. Slips and Falls
  4. Restraint Use
  5. Serious Event Reports
  6. DVT/PE
  7. Surgical Time-out

- F. Targets for improvement, will be determined by the Patient Safety Committee. This aggregate data will be reported to the Patient Safety Team at quarterly intervals.
- G. Implementation of new processes, or redesign of current processes, will incorporate patient safety principles and an emphasis on the important hospital and patient care functions of:
- |                     |                                       |                                      |
|---------------------|---------------------------------------|--------------------------------------|
| Patient Rights      | Patient/Family Education              | Improving Organizational Performance |
| Patient Assessment  | Continuum of Care                     | Management of Information            |
| Care of the Patient | Leadership                            | Management of Human Resources        |
| Infection Control   | Management of the Environment of Care |                                      |
- H. The procedures for immediate response to medical/health care error are as follows:
1. Staff will immediately report the event to the supervisor/administrator.
  2. The supervisor will immediately communicate the event to the Patient Safety Officer to initiate investigation and follow-up actions.
  3. Staff will complete the Incident/Occurrence Report to preserve information.
  4. Staff will obtain required orders to support the patient's clinical condition.
  5. 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 Team, as applicable.
- I. Solicitation of input and participation from patients and families in improving patient safety will be accomplished by:
1. Conversations with patients and families during administrative rounds
- J. Procedures used in communicating with families the organization's role and commitment to meet the patient's right to have unexpected outcomes or adverse events explained to them in an appropriate, timely fashion include:
1. Patient's rights statements
  2. Patient responsibilities—A list of patient responsibilities will be included in the admission information booklet. These responsibilities include the patient providing correct information about perceived risks and changes in their condition, asking questions, following instructions, accepting consequences, following facility rules, etc.
  3. Annual assessment for information barriers to effective communication among caregivers.
- K. Methods to assure ongoing inservices, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:
1. Providing information and reporting mechanisms to new staff in the orientation training
  2. Providing ongoing education, including reporting mechanisms during annual training.
  3. Obtaining a confidential assessment of staff's willingness to report medical errors at least annually
  4. Testing staff knowledge regarding patient safety in competency testing
  5. Evaluating staff knowledge levels and participation of patient safety principles in annual performance appraisals.

# VALLEY VIEW SURGERY CENTER

## Chapter 5.3.1

### Policy: Quality Management and Improvement

### Subject: Sentinel Events: Safety Plan

Effective Date: 07/12

Revision/Reviewed Date: 07/2012, 08/13, 12/13, 03/15

Page 1 of 5

---

## SAFETY PLAN

### Components of Plan:

#### NRS439.875

**I. Patient Safety committee** –The Patient Safety Committee will fulfill the functions as required by NRS439.875.

#### A. Composed of

- The infection control officer (ICO) of the medical (1) facility Patient Safety Officer (PSO) of (1).VVSC. The ICO will fulfill the designation and duties as required by NSR439.873.
- The patient safety officer (PSO) is employed by VVSC (2) facility. The PSO will fulfill the designation and duties as required by NSR439.870.
- At least three providers of health care who (3) treat patients at VVSC facility, including, without limitation, at least one member of the medical, nursing and contract Consultant Pharmacist VVSC.
- One member of the executive or governing body (4) of VVSC.

#### B. Meetings

- shall meet at least once (b) each month.
- Receive reports from the patient safety officer.
- Evaluate actions of the patient safety officer in (b) connection with all reports of sentinel events alleged to have occurred at VVSC.
- Review and evaluate the quality of measures carried (c)(d) out by VVSC to improve the safety of patients who receive treatment at the medical facility.
- Make recommendations to the Governing (e) Body of VVSC to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- At least once each calendar quarter, report to the (f) executive or governing body of the medical facility regarding:
  - The number of sentinel events that occurred (1) during the preceding calendar quarter;
  - The number and severity of infections that (2) occurred during the preceding calendar quarter; and
  - Any recommendations to reduce the number and (3) severity of sentinel events and infections that occur at VVSC.

C. Adopt patient safety checklists and patient safety (g) policies etc, as required by [NRS 439.877](#),

- See NRS439.877 at end of Safety Plan

D. Same privilege and protection

- 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 [NRS439.655](#).



Chapter 5.3.1

Policy: Quality Management and Improvement

Subject: Sentinel Events: Safety Plan

Effective Date: 07/12

Revision/Reviewed Date: 07/2012, 08/13, 12/13, 03/15

Page 2 of 5

---

**II. Mandatory Reporting of sentinel events. NRS 439.835**

- A. 1. Any person employed by VVSC 1. (a) will, within 24 hours after becoming aware of a sentinel event that occurred at VVSC, notify the patient safety officer of VVSC of the sentinel event; and the patient safety officer shall, within 14 days (b) after receiving notification pursuant to paragraph (a), report the date, the time and a brief description of the sentinel event to: The Health Division; and (1) The representative designated pursuant to (2) [NRS 439.855](#), if that person is different from the patient safety officer.
- B. If the patient safety officer of MDS 2. personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at VVSC, the patient safety officer shall, within 14 days after discovering or becoming aware of the sentinel event, report the date, time and brief description of the sentinel event to: The Health Division; and (a) The representative designated pursuant to (b) [NRS 439.855](#), if that person is different from the patient safety officer.
- C. The State Board of Health shall prescribe the manner 3. in which reports of sentinel events must be made pursuant to this section.

**III. Notification of patients involved in sentinel events. NRS439.855**

VVSC 1. designates the PSO to notify the patients who have been involved in sentinel events at VVSC. The PSO, 2. will not later than 7 days after discovering or becoming aware of a sentinel event that occurred at VVSC, provide notice of that fact to each patient who was involved in that sentinel event. The provision of notice to a patient Pursuant to 3. subsection 2 must not, in any action or proceeding, be considered an acknowledgment or admission of liability.

**IV. Provision of certain information relating to facility-acquired infections to patients NRS439.856**

VVSC will provide to each patient of VVSC (a) upon admission of the patient, the general and facility-specific information relating to it's acquired infections: 2. Post in publicly accessible areas of the VVSC (b) VVSC's information on reporting facility-acquired infections, including, without limitation, the contact information for making reports to the Health Division. The contact information is noted in the posted Patient's Bill of Rights.

The information provided to each patient pursuant to must include, without limitation: The measures used by VVSC as stated in VVSC's Infection Control and Prevention Program and Plan for (a) preventing infections, including facility-acquired infections; Information on determining whether a patient had an (b) infection upon admission to the VVSC, risk factors for acquiring infections and determining whether an infection has been acquired; Information on preventing VVSC acquired (c) infections;

Posted instructions on the Patients Bill of Rights for reporting facility-acquired

## VALLEY VIEW SURGERY CENTER

### Chapter 5.3.1

#### Policy: Quality Management and Improvement

#### Subject: Sentinel Events: Safety Plan

Effective Date: 07/12

Revision/Reviewed Date: 07/2012, 08/13, 12/13, 03/15

Page 3 of 5

---

(d) infections, including, without limitation, the contact information for making reports to the Southern Nevada Health District at 702 759-1099, State Health Division (BHQC) at 775-684-4002; and any other information that the VVSC (e) deems necessary

#### **V. Procedure for informing patient, legal guardian or other person that patient at VVSC has infection, immunity from liability for providing certain information. NRS439.857**

Except as otherwise provided in subsection 2, when VVSC confirms that a patient at at its facility has an infection, the PSO shall, as soon as practicable but not later than 5 days after the diagnosis is confirmed, inform the patient or the legal guardian or other person authorized by the patient to receive such information that the patient has an infection. The PSO may delay providing information about an infection 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; (a) Is not conscious; or (b) In the judgment of the provider of health care, is (c) likely to harm himself or herself if informed about the infection. If the PSO delays providing information about an infection pursuant to subsection 2, such information must be provided as soon as practicable after: The patient is capable of understanding the (a) information; The patient regains consciousness; (b) In the judgment of the PSO, the (c) patient is not likely to harm himself or herself if informed about the infection; or A legal guardian or other person authorized to (d) receive such information is available. VVSC shall ensure that the providers 4. of health care of the VVSC follows its protocols in accordance with this section that provide the manner in which a provider of health care or his or her designee must: Inform a patient or the legal guardian or other (a) person authorized by a patient to receive such information that the patient has an infection with 5 days of determination; and If known or determined while a patient remains at (b) VVSC, inform the patient or the legal guardian or other person authorized by the patient to receive such information whether the infection was acquired at the VVSC and of the apparent source of the infection.

A person or governmental entity who, with reasonable 5. care, informs a patient or the legal guardian or other person authorized by the patient to receive such information that an infection was not acquired at the medical facility and of the apparent source of the infection pursuant to subsection 4 is immune from any criminal or civil liability for providing that information.

#### **VI. Patient safety checklists and patient safety policies: Adoption by patient safety committee; required provisions; duties of patient safety committee. NRS439.877**

The patient safety committee established pursuant to 1. [NRS 439.875](#) by VVSC

Adopts patient safety checklists and patient safety policies for use by: Providers of health care who provide treatment to (a) patients at VVSC; Other personnel of VVSC who provide (b) treatment or assistance to patients; Employees of VVSC who do not provide



**Chapter 5.3.1**

**Policy: Quality Management and Improvement**

**Subject: Sentinel Events: Safety Plan**

**Effective Date: 07/12**

**Revision/Reviewed Date: 07/2012, 08/13, 12/13, 03/15**

**Page 4 of 5**

---

(c) treatment to patients but whose duties affect the health or welfare of the patients at the VVSC, and Persons with whom the medical facility enters into a (d) contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at VVSC. e.g. cleaning services. The patient safety checklists adopted pursuant to subsection 1 must follow protocols to improve the health outcomes of patients at VVSC 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 VVSC and contractors with VVSC 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 VVSC which includes, without limitation, verifying that the patient received: Proper 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 VVSC.

The patient safety policies adopted pursuant to 3. subsection 1 must include, without limitation: A policy for appropriately identifying a patient (a) 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 includes, without limitation, the name and date of birth of the patient. A policy regarding the nationally recognized (b) standard precautionary protocols to be observed by providers of health care at VVSC including, without limitation, protocols relating to hand hygiene. A policy to ensure compliance with the patient (c) safety checklists and patient safety policies adopted pursuant to this include, without limitation, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

The patient safety committee shall: 4. Monitor and document the effectiveness of the (a) patient identification policy adopted pursuant to paragraph (a) of subsection 3.

At least annually, review the patient safety (b) 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. Revise a patient safety checklist and patient safety (c) 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.

On or before July 1 of each year, submit a report to (d) 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).

# VALLEY VIEW SURGERY CENTER

## Chapter 5.3.1

### Policy: Quality Management and Improvement

#### Subject: Sentinel Events: Safety Plan

Effective Date: 07/12

Revision/Reviewed Date: 07/2012, 08/13, 12/13, 03/15

Page 5 of 5

---

#### References

1. [NRS 439.875](#). (Added to NRS by [2002 Special Session, 15](#); A [2011, 679, 1584](#), effective January 1, 2012)
2. NRS 439.835 (Added to NRS by [2002 Special Session, 13](#); A [2009, 553](#))
3. **NRS439.855** (Added to NRS by [2002 Special Session, 14](#))
4. **NRS439.856** (Added to NRS by [2011, 1580](#), effective January 1, 2012)
5. **NRS439.857** (Added to NRS by [2011, 1581](#))
6. **NRS439.877**(Added to NRS by [2011, 677](#))

Reference: AAAHC Standards, Quality Management and Improvement, *Patient Safety Plan*, Section 5.3.1  
NRS 439.805 to 439.890, NAC 439.915

# **CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 2016**

## **Patient Safety Plan**

All Nevada mandatory reporting medical facilities must have a Patient Safety Plan to improve the health and safety of patients who they treat (per NRS 439.865). The facility shall submit its plan to the governing board of the facility for approval in accordance with the requirements set forth by NRS 439.865. After the patient safety plan is approved, the facility should notify all providers of health care who provide treatment to patients of the existence of the plan and of its requirements. A medical facility shall require compliance with its patient safety plan.

The Patient Safety Plan is submitted to the State Health Division yearly, or upon request.

The Quality and Patient Safety Plan describes the multidisciplinary, systematic performance improvement framework developed by The Center For Surgical Intervention (TCSI) to improve patient outcomes, reduce the risks associated with patient safety and assuring a safe environment. The patient safety program is integrated with all infection control and prevention, quality and performance improvement activities.

TCSI strives to promote a culture of patient safety. Reporting of patient safety events is the basis of this culture and allows TCSI to identify areas for improvement. TCSI is committed to patient safety, teamwork, collaboration and honest, open communication. The contribution of physicians, nurses and staff is valued in the pursuit of clinical excellence and safe patient care. Early identification of system and process issues is key to sustaining a culture of patient safety. TCSI 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 TCSI's commitment to the community it serves.
- Unite TCSI and individuals who work and practice at TCSI 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 TCSI 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 TCSI.
- To encourage an environment that supports safety, encourages blame free reporting, addresses maintenance and improvement in patient safety issues in our facility and establishes mechanisms for the disclosure of information related to errors.

The Center for Surgical Interventions leadership and staff must participate in the performance improvement activities to support patient safety.

## **II. SCOPE:**

## **CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 2016**

The Center for Surgical Intervention Patient Safety Plan is an all-inclusive, integrated method of 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.

- All Center for Surgical Intervention employees.
- All patient services provided by our staff or through contracted services.
- Focus on quality indicators that affect patient safety and patient health outcomes.
- Perform QI studies on key processes and outcomes in our facility, use this data to analyze our performance in patient safety areas and find solutions for improving systems or processes.

Important aspects of patient care and service that involves the monitoring of activities and making improvements include:

1. Data from internal monitoring of patient/employee safety
  - Processes that affect a large percentage of patients/employees
  - Processes that place patients/employees at risk:
    - a. If not performed well
    - b. If performed when not indicated
    - c. If not performed when indicated
  - Processes that have been or are likely to be problem-prone
  - The types of occurrences to be addressed include, but are not limited to, near misses and actual events related to:
    - Adverse Drug Reactions
    - Post procedure bleeding
    - Surgical Site Infection
    - Medication errors/Look alike sound alike medications
    - Allergic reaction
    - Medical Equipment related adverse event
    - Technical difficulty with procedure
    - Proper indication
    - Proper consent
    - Current H & P
    - Risk Stratification
    - 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

## **CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 2016**

- 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
- Healthcare-associated Infection (HAI) Prevention
- Fire Prevention and Safety in the Surgical Rooms
- Visitor safety /Visitor incidents
- Employee safety
  - Blood/body fluid exposures
  - Occupational diseases
  - Communicable disease exposures
  - Musculoskeletal injuries

### **Environmental safety**

- Product recalls
- Drug recalls
- Product/equipment malfunction
- Construction – Infection Control Risk Assessment
- Water quality
- Air quality
- Disaster planning
- Security incidents
- Workplace violence

2. Data from external sources, including but not limited to:
  - a. Agency for Healthcare Research and Quality (AHRQ)
  - b. Centers for Disease Control and Prevention (CDC)
  - c. Institute for Healthcare Improvement (IHI)
  - d. Institute for Safe Medication Practices (ISMP)
  - e. JCAHO Standards and Sentinel Event Alerts
  - f. National Forum for Healthcare Quality Measurement and Reporting (NQF)
  - g. Occupational Safety and Health Administration (OSHA)
  - h. Published literature

### **Surgical Infection Prevention**

SCIP- Inf-1 Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision-Surgical patients who received prophylactic antibiotics within one hour prior to surgical incision.

## **CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 2016**

\*Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics administered within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.

SCIP- Inf-2 Prophylactic Antibiotic Selection for Surgical Patients- Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).

SCIP- Inf-6 Surgery Patients with Appropriate Hair Removal- Surgery patients with appropriate surgical site hair removal. No hair removal, or hair removal with clippers or depilatory is considered appropriate. Shaving is considered inappropriate.

### **VTE**

SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered - Surgery patients with recommended venous thromboembolism (VTE) prophylaxis ordered during the admission.

### **Improve Patient Safety & Quality**

- Monitor compliance with National Patient Safety Goals
- Monitor risk reports for trends in safety issues
- Evaluate process for DVT assessment on admission

### **Ambulatory 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**

- 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.

#### **Use medicines safely**

- 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.
- Take extra care with patients who take medicines to thin their blood.

#### **Prevent infection**

- 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.
- Use proven guidelines to prevent infection after surgery.

# **CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 2016**

Prevent mistakes in surgery

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

The Center for Surgical Intervention recognizes that patient safety is a priority that includes establishing, maintaining and improving the safety of patients throughout their care experience.

### **III. STRUCTURE:**

#### **Governing Body**

The Governing Body of the Center for Surgical Intervention (TCSI) is comprised of members including: Medical Director and Facility Administrator. 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 Center for Surgical Intervention (TCSI) 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 the TCSI 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 represents the TCSI 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.

## **CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 2016**

- 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.

### **Patient Safety Officer**

A medical facility shall designate an officer or employee of the facility to serve as the patient safety officer of the facility per NRS 439.870.

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:

- 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.
- Comply with the organization's reporting responsibilities to the State by assuring that all serious events and infrastructure failures are reported within required time frames. Use the NV Contact Form to update the Patient Safety Officer or Sentinel Event Reporter for the facility, as needed

### **Patient Safety Committee**

The Patient Safety Committee is comprised of the Medical Director, Administrator, Director of Nursing, Patient Safety Officer and the Radiation Safety Officer and nursing staff. The Patient Safety Committee is responsible to the Governing Body and Administration for the overall operation of the Performance Improvement and Patient Safety Plan. The Patient Safety Committee meets on a quarterly basis or as needed. Patient Safety Goals will be developed annually or as needed.

The duties of the Patient Safety Committee include:

- Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the facility.
- Review all adverse outcomes.
- 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.



## CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 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.

### Coordination with Quality Improvement

To the extent possible, and in a manner consistent with the protection of confidentiality of the facility's staff and medical staff quality assurance data.

### IV. Definitions

*Sentinel event* – Is defined 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 (NRS 439.830)

**NRS 439.830 “Sentinel event” defined.** “Sentinel event” means 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.

(Added to NRS by 2002 Special Session, 13; A 2005, 599)

### **NRS 439.835 Mandatory reporting of sentinel events.**

1. Except as otherwise provided in subsection 2:

(a) A person who is employed by a medical facility shall, within 24 hours after becoming aware of a sentinel event that occurred at the medical facility, notify the patient safety officer of the facility of the sentinel event; and

(b) The patient safety officer shall, within 13 days after receiving notification pursuant to paragraph (a), report the date, the time and a brief description of the sentinel event to:

(1) The Health Division; and

(2) The representative designated pursuant to NRS 439.855, if that person is different from the patient safety officer.

2. If the patient safety officer of a medical facility personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at the medical facility, the patient safety officer shall, within 14 days after discovering or becoming aware of the sentinel event, report the date, time and brief description of the sentinel event to:

(a) The Health Division; and

(b) The representative designated pursuant to NRS 439.855, if that person is different from the patient safety officer.

3. The State Board of Health shall prescribe the manner in which reports of sentinel events must be made pursuant to this section.

(Added to NRS by 2002 Special Session, 13; A 2009, 553)

**NRS 439.837 Mandatory investigation of sentinel event by medical facility.** A medical facility shall, upon reporting a sentinel event pursuant to NRS 439.835, conduct an investigation

## **CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 2016**

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.  
(Added to NRS by 2009, 3068)

*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<sup>†</sup> 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.

*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.

*Adverse Event/Incident/Complication* – An unintended act which leads to an unexpected outcome regarding patient or employee. This would be any occurrence that is not consistent with the normal operations of the ASC of Southern Nevada or the anticipated disease/treatment process of a patient. An adverse event can also be categorized as either a sentinel event or a near miss. Examples of adverse events/incidents that would require the use of an incident form include but are not limited to:

- Patient Fall
- Theft
- Employee injury

### **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.

The Center for Surgical Intervention (TCSI) encourages all employees to report any errors or work methods that may lead to potential adverse patient outcomes. The TCSI 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

## **CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 2016**

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.

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 Tracking System*

1. All information regarding Complications and Adverse events are 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 occurrence, improve quality care and ensure patient and visitor safety.

### *C. Sentinel Events*

When a sentinel event occurs, appropriate individuals are notified and immediate action/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.

### *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 prior to the procedure being performed. A written copy is provided to them for review.

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.

## **CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 2016**

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 asks for assistance 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.
16. Patient Identification - NRS 439 - requires providers of health care positively to identify the patient upon each interaction- using two patient identifiers
  - Ongoing monitoring by direct observation technique, concurrent and retrospective medical record review for the full compliance of Patient Identification process
  - Staff education and acknowledgement to establish the responsibility and accountability

### **VII. Staff Education**

1. Provide initial and annual training to all employees on safety in the work environment.
2. Staff education on safety checklist ie. preop, intr op and discharge.
3. Surgical Site Infection and HAI, Hand Hygiene, Blood Borne Pathogens and Personal Protective Equipment training is provided to staff.
4. Educating and following the Time Out Policy to assure that we have the right patient and the right procedure.
5. Using 2 patient identifiers at each interaction with patient. Importance of verifying arm band for the correct patient and allergies.
6. Staff meetings are held to communicate quality improvement and patient safety issues.
7. Ongoing education to staff is provided regarding patient safety issues.
8. Staff education on all disinfectants used throughout the facility.

### **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.
- *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

## CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 2016

High Alert Medication Policy.

- *Medication Safety*
  - Do Not Use Abbreviations
  - Medication Reconciliation
  - Black Box Warning Drugs
  - Look alike Sound alike Drugs
- *Infection Surveillance* – Infection surveillance will be completed by the Director of Nursing 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 the Director of Nursing 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, Administration and the Governing Board.
- *Monthly Surgical Site Infection Control Reports* – Physicians communicate to the Director of 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 instruments are placed in the automated sterilizer, 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 instrument is placed in the machine. All checks are documented in 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. During employee orientation clinical staff completes the Safe Injection Online Training Course. The training consists of ten sections related to infection control and specifically injection safety including ethical considerations and policies and procedures related to injection safety. It also utilizes video clips from the CDC training video for safe injection practices to illustrate concepts discussed in the text.

## **CENTER FOR SURGICAL INTERVENTION PATIENT SAFETY PLAN 2016**

- *Transfers* – Any patient transferred to the hospital post procedure will have a peer review process performed.
- *Safety Checklists*- This new law requires the patient safety committees to adopt patient safety checklists and policies aimed at improving the health outcomes of patients. The patient safety committee is required to review the checklists and policies on an annual basis, making revisions as necessary. The law also requires annual reporting to the Nevada Legislative Committee on Health Care by the patient safety committees. The patient safety checklists and policies are to be included in the medical facility's patient safety plan. Failure to adopt a patient safety plan or establishment of a patient safety committee may result in administrative sanctions.

The law requires checklists for the following:

- Checklists related to specific types of treatment.
- Checklists to ensure that employees and contractors of the medical facility who are not healthcare providers follow protocols to ensure the patient's room and environment are sanitary.

A discharge checklist that includes verifying the patient received proper instructions for prescription medications, instructions concerning aftercare, any other instructions concerning the patient upon discharge.

### **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 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.

### **Disclosure to Patient**

Senate Bill No. 339 (*Patients to be Informed about Hospital Acquired Infections, 2011*)  
Requires providers to inform patients about infections acquired during a hospital stay.

### **References**

The Joint Commission for Accreditation of Health Care Organization: [www.jointcommission.org](http://www.jointcommission.org)

Institute for Safe Medication Practices- [www.ismp.org](http://www.ismp.org)

Adapted from the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services,  
Quality Tools found in <http://www.qualitytools.ahrq.gov/resources/glossary.aspx>.

## **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 are well educated for post-operative self-management, (including their understanding of medications)
- Providers are fully informed of their patient's physical status as it pertains to their surgery/procedure
- The surgery/procedure is appropriately performed (correct-site) and clinically accurate

#### **Review:**

##### **Safe Environment of Care**

Tenaya Surgical Center will follow the guidelines set forth in 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. Obesity (equal to or greater than 20% more than the ideal weight)
11. End-stage renal disease

##### **Risk Assessment:**

The pre-operative assessment process starts when the surgeon or the procedurist 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.

## 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 Tenaya Surgical Center. It is up to the discretion of the operating surgeon or procedurist 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. The Association of periOperative Nurses (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
- Signs of abuse or neglect (if applicable)
- Cultural, emotional, and socioeconomic assessment
- Pain assessment
- Medication history, including over-the-counter medications, herbal medications and supplements, and illicit drugs. This also includes the frequency, dosage and time last dose taken
- Anesthetic history
- 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 procedurist notified so he/she can answer any questions the patient may have.
- 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 at all 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 proceduralist and anesthesiologist to allow this to happen. If allowed, the patient will spend a longer period of time in the PACU, anywhere from one to four hours, depending on the circumstances and the alertness of the patient. 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.

For pediatric patients, we have a special transfer agreement set up with University Medical Center, thus eliminating the tertiary facility.

### 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.

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"

# 2016 Ambulatory 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

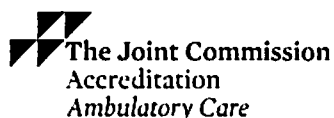
- NPSG.03.04.01 Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
- NPSG.03.05.01 Take extra care with patients who take medicines to thin their blood.
- NPSG.03.06.01 Record and 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](http://www.jointcommission.org).



## SUNSET RIDGE SURGERY CENTER, L.L.C.

MANUAL:	Policy & Procedure	Effective Date:	7/21/2014
SECTION:	Safety Management Plan	Reviewed Date:	7/01/2015
POLICY:	14.20 Patient Safety Program	Revised Date:	7/21/2014

---

**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

# **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 determined 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:

Names have been

Administrator:

removed based on

QI Coordinator/D.O.N.:

NRS439.843.

Business Office Manager:

OR Supervisor:

PACU & Pre-Op Supervisor:

Ad HOC members:

Pharmacy Consultant:

Laboratory Consultant:

Environmental Consultant:

Housekeeping Services:

Medical Executive Committee:

Radiology Consultant:

SUMMIT Surgery Center

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 Credentialed 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	

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 1 OF: 10
	EFFECTIVE: 6/01/08
APPROVED BY: Board of Managers	REVISED:

**PURPOSE:**

- The purpose of the organizational Patient Safety Plan at Stonecreek Surgery 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 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 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 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 Stonecreek Surgery Center. The Patient Safety Plan, developed by the 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 #6016
	PAGE: 2 OF: 10
	EFFECTIVE: 6/01/08
APPROVED BY: Board of Managers	REVISED:

## **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
    - 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.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 3 OF: 10
	EFFECTIVE: 6/01/08
APPROVED BY: Board of Managers	REVISED:

- 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):
    - Surgery or invasive procedure performed on the incorrect patient or incorrect body part
    - The unintentional retention of a foreign object, i.e., sponge, instrument, in a postoperative or postinvasive procedure patient
    - All identified cases of unanticipated death or major permanent loss of function associated with a healthcare associated infection
    - 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
- 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 area throughout the facility. There will be an emphasis on important facility and patient care functions of:

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 4 OF: 10
	EFFECTIVE: 6/01/08
APPROVED BY: Board of Managers	REVISED:

- 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

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 5 OF: 10
	EFFECTIVE: 6/01/08
APPROVED BY: Board of Managers	REVISED:

- Methodology:
  - The Safety Committee is responsible for the oversight of the Patient Safety Program.
  - **All areas** within the organization (patient care and non-patient care areas) are responsible to report patient safety occurrences and potential occurrences to the Safety Committee, who will aggregate occurrence information and present a report to the Quality Assurance Committee on a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per clinical area, occurrence impact on the patient, remedial actions taken, and patient outcome. The Quality Assurance Committee will analyze the report information and determine further patient safety activities as appropriate.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 6 OF: 10
	EFFECTIVE: 6/01/08
APPROVED BY: Board of Managers	REVISED:

- 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 - 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 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 Quality Assurance Committee per organizational policy.
- Any individual in any clinical area 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 Quality Assurance Committee per organizational policy.
- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:



SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 7 OF: 10
	EFFECTIVE: 6/01/08
APPROVED BY: Board of Managers	REVISED:

- 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 Quality Assurance Committee 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 Quality Assurance Committee per organizational policy.
  - ◆ Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the attending physician 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 Quality Assurance Committee per organizational policy.
- 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 Quality Assurance Committee 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.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 8 OF: 10
	EFFECTIVE: 6/01/08
APPROVED BY: Board of Managers	REVISED:

- 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 Quality Assurance Committee.
- Established organizational policy (such as the Sentinel Event Policy) 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 Quality Assurance and Safety Committee's 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 #6016
	PAGE: 9
	OF: 10
	EFFECTIVE: 6/01/08
APPROVED BY: Board of Managers	REVISED:

- 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. 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 Quality Assurance Committee and the individual staff member's 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 Quality Assurance Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Quality Assurance 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.
  - As part of this organization's culture of safety, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to The Accreditation Association for Ambulatory Health Care (AAAHC). 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 AAAHC.
  - On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 10 OF: 10
	EFFECTIVE: 6/01/08
APPROVED BY: Board of Managers	REVISED:

- 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.
- 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 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 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.
- Patient safety reports from the Environment of Care Committee will be submitted to the organizational Quality Assurance 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 Quality Assurance Committee, with all information submitted held under the auspices of the Quality Assurance Committee.
- 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.

# **Spring Valley Surgery Center LLC**

## **2015 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

### **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.**

# **QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN**

## **SPECIALTY SURGERY CENTER 2016**

The mission of 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.

In keeping with the mission of Specialty Surgery Center and community standards for ambulatory surgical care, this plan allows for a planned, systematic, organization-wide approach to the quality improvement process, reducing risks through an effective risk management plan and 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 and human resources. The overall strategies of the program include

- Improving patient safety and reducing risk to patients,
- Reducing medical/health 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 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 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
- Infection Control Strategies
- Medication Safety
- Radiation Safety

### **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.

In early 2016 Specialty 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. 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 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 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 (NWF)

**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, 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. 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 or not the patient was harmed (NWF).

**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 and 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).

**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:** 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).

**Root Cause Analysis (RCA):** A method of problem solving that tries to identify the root causes of faults or problems. RCA practice tries to solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing 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 root cause analysis. RCA is typically used as a reactive method of identifying event(s) causes, revealing problems and solving them. The RCA findings are reported at the quality meetings, MEC and GB meetings. In 2016 the ASD will be moving toward an online program for analysis of serious events called Serious Event Analysis (SEA).

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/health 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 incident reports and litigations for trends.
- Reviewing and tracking of all adverse outcomes, near misses 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 meet these 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 or safety 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 department/leader 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 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 and families, 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 and creating a safe environment.

### **Peer Review**

Ambulatory Surgery Centers are required by AAAHC, CMS, and other regulatory agencies to conduct quality improvement and peer review. Peer review activities include ongoing random review, specialty specific review and review of complications. Cases with complications are reviewed by the physicians within the same specialty as the physician under review.

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. Specialty Surgery Center leadership includes the Governing Body, Medical Executive Committee; the facility based Medical Directors, Administrators, Risk/Quality/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/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/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 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 support 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 2015, upon approval from the MEC and Governing Body:

Quality Improvement Committee Chair:      Names have been removed based on  
**NRS439.843.**

Risk Manager:

Infection Control Coordinator:

Patient Safety Committee Chair:

### **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 10 days of employment as part of the 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 Specialty 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 for 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
  - "Near miss" event
  - 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 include at a minimum:
    - 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 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 (to include capnography – end title CO2 monitoring)
- 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
- 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
- Sleep Apnea assessment

### **Intra-op Care and Processes**

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

### **Complications**

- Unexpected complications
- Post op DVT's/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

### **Resuscitation**

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

### **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 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**

- 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)
- OSHA training during orientation and annually
- Employee, physician, allied health and patient exposures

- Appropriate sterilization processes for instrumentation
- Appropriate endoscopy re-processing
- Monitoring of temperature of rooms and equipment.
- 24/7 Monitoring of temperature and humidity of designated rooms.

#### **Provision of Care/ Medical Record Review**

- 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.
- 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

#### **Safety**

- Surveillance rounds and corrective follow up on deficiencies
- Process for notifying and following through on recalls
- Fire drills
- Emergency preparedness drills
- Infant/child abduction drill
- Sharps prevention program
- Active Shooter drill

#### **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 abbreviations
- Latex allergy precautions
- Falls prevention guidelines
- DVT assessment
- Close calls
- Hand off communication

## **QI/RISK GOALS for 2016**

### **2016 Clinical Agenda:**

- Medication Safety Program
- Infection Control Toolkit
- Medical Director Engagement

### **2016 Division Goals:**

- To continue to reduce the number of sharp occurrences. (In 2014 the Division reported 20 occurrences and in 2015 the Division reported 17 sharp occurrences).
- To continue to reduce the number of falls. (In 2014 there were 25 falls reported within the Division and in 2015 with the implementation of the falls toolkit, the falls reported rate decreased to 14 reported falls in 2015).
- To complete the 2016 Risk Reduction Program Initiatives
- To meet the 2016 ASD Clinical Objectives

### **2016 Center Goals:**

- To reduce the number of falls within the facility
- To reduce sharp incidents within the facility – staff will review systems by 3<sup>rd</sup> quarter 2016
- To continue to monitor for compliance with past agenda items to ensure full compliance.



## Surgical Care Affiliates



## The Surgical Center at Tenaya

# Performance/Quality Improvement and Patient Safety Plan

## The Surgical Center at Tenaya

***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

**I PURPOSE**

The purpose of The Surgical Center at Tenaya Performance /Quality Improvement and Patient Safety Program is to strive to improve the quality of care and promote more effective and efficient utilization of facilities and service, maintain an active, ongoing, integrated, organized, peer-based program of quality management and improvement that links peer review, quality improvement activities and risk management in an organized, systematic way. The program is driven by facility leadership and aligned with the mission, vision and strategic objectives of The Surgical Center at Tenaya, which strives to ensure risk to patients and others are minimized, and errors in the delivery of services are identified and prevented or reduced. The program assesses processes, systems and patient outcomes and improves them on a priority basis by selecting quality indicators, measuring, and analyzing information related to these indicators, adverse patient events, and other aspects of performance, regularly. When identified, necessary changes are implemented and incorporated into appropriate processes, products or services and performance is tracked to assure improvements are sustained over time. Successful performance improvement and patient safety require a multidisciplinary and multi-faceted approach which minimally includes the following key elements:

- A** Measuring performance through standardized data collection and utilization of data measurement to assess current performance.
- B** Identification and management of opportunities for improvement.
- C** Leadership-driven prioritization for and communication of performance improvement activities.
- D** Implementation of Clinical Practice Guidelines to improve quality and reduce variation of care in specific diagnoses, conditions or symptoms.
- E** Effectively reducing factors that contribute to unanticipated events or negative outcomes through ongoing, systematic, risk assessment and reduction.
- F** Identification, reporting, analyzing and managing sentinel events and near miss events.
- G** Implementation of a patient safety plan.

The Surgical Center at Tenaya shall utilize the model described in this plan to assess and improve its performance in patient and facility functions. The ultimate goals of the facility performance improvement plan are to provide safe, patient care in a cost effective manner and to achieve excellent clinical outcomes.

The Surgical Center at Tenaya plan delineates the respective roles of the facility's Governing Body, medical leadership, clinical staff, management and all employees in developing, implementing, evaluating, and coordinating a comprehensive performance improvement and patient safety program.

The plan outlines how the facility approaches performance improvement and patient safety in a systematic, facility-wide and collaborative fashion and shall include all staff involved directly or indirectly with the provision of patient care services.

Annually, an evaluation of the Performance /Quality Management and Patient Safety Program is performed. The evaluation summarizes the goals and objectives of the Plan, the quality improvement activities conducted during the past year, and the quality improvement initiatives taken in response to findings. Defined goals and specific objectives to be accomplished for the next year will be identified.

**II STRUCTURE**

***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

To ensure that a planned, systematic facility and organization-wide approach to performance improvement and patient safety is implemented, the following structure has been established:

**A Leadership**

Strong leadership, direction and support of quality and performance improvement activities by the Governing Body and Administrator are key to performance improvement. This involvement of facility leadership assures that quality and performance improvement initiatives are consistent with provider mission and/or strategic plan. The Governing Body provides leadership for the quality and performance improvement process as follows:

- ☐ Ensuring the quality and performance improvement program is defined, implemented and maintained by the facility. The Performance/Quality Improvement and Patient Safety Plan is reviewed, evaluated and approved annually.
- ☐ Addressing the facility's priorities and that all improvements are evaluated for effectiveness.
- ☐ Specifying data collection methods, frequency and details.
- ☐ Clearly establishing a culture and the expectations for safety.
- ☐ Adequately allocating sufficient staff, time, information systems and training to implement the program.

**B Regional Quality Council**

The Regional Quality Council is made up of facilities within a geographic region that come together and pool resources to improve the overall quality of patient care for their region. The purpose of the council will be to:

- ☐ Share and compare data from clinical and operational indicators for purposes of external benchmarking
- ☐ Review of accreditation activities, updates and resources, including Sentinel Event Alerts and National Patient Goals
- ☐ Express concerns and needs of each respective facility, collaborating with productive dialogue and exchange of ideas
- ☐ Receive education as needed in areas of medical staff affairs/credentialing, environment of care, infection control, performance improvement, medication safety, etc.

The Regional Quality Council shall meet in person or via conference calls a minimum of quarterly and will maintain documented minutes of each meeting, utilizing the SCA standard minutes format. Composition of the Regional Quality Council will be the Regional Quality Coordinator and at least one representative from each facility in the region. Each facility Administrator in the region will be apprised of the activities of the Regional Quality Council for reports to the MEC and the facility's Governing Body.

**C Facility Quality Council**

The Surgical Center at Tenaya has an established Quality Council (QC) to monitor and guide the direction of the facility's performance improvement and patient safety activities. The purpose of this council shall be to:

- ☐ Improve the performance of the facility and organization by setting goals and objectives.
- ☐ Encourage participation of health care professionals, one of which is a Physician.
- ☐ Review/coordinate performance improvement, risk assessment, infection control, utilization management, environmental safety, research and patient safety activities.
- ☐ Ensure that measurement activities are complete, reliable, valid and accurate on an ongoing basis.

***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

- ☐ Ensure that internal and external benchmarking activities occur.
- ☐ Identify performance improvement/risk assessment and patient safety projects.
- ☐ Act on information to improve facility performance.
- ☐ Prioritize Performance Improvement projects. PI projects address clinical, administrative, and cost-of-care performance issues, as well as, actual patient outcomes, i.e., results of care, including safety of patients. Focus is placed on high risk, high volume and problem-prone areas, considering the incidence, prevalence, and severity of problems in those areas.
- ☐ Identify team members for the Performance Improvement projects.
- ☐ Review facility and departmental reports.
- ☐ Identify, research and implement leadership-approved Clinical Practice Guidelines.
- ☐ Monitor and report the effectiveness of the actions taken over time to ensure improvements are sustained.
- ☐ Show linkages between Performance/Quality Improvement activities, peer review, and the risk management program.
- ☐ Report findings from the QC to MEC, GB, and throughout the facility and organization as appropriate.
- ☐ Evaluate the overall effectiveness of the program at least annually.

The Surgical Center at Tenaya QC shall meet at least quarterly and will maintain documented minutes of each meeting. The facility shall determine the composition of this council to include a representative of clinical, non-clinical, administrative and medical staff members. The facility QC also serves as the venue for Safety, Infection Control and Risk Management data review and analysis.

**D Performance Improvement Teams**

Performance Improvement (PI) Teams shall be developed at the discretion of the QC, with the approval of the Administrator, to address opportunities for improvement identified via the facility's various sources of data collection and measurement. The PI team is formed to design and implement interventions. The PI teams are designed to serve as ad-hoc teams and are disbanded once a specific project is completed. Assignments will generally be areas that cross various clinical and non-clinical departments and services or functions of the organization. PI teams will be comprised of multidisciplinary members as appropriate based on the actual project.

**E Quality Coordinator**

The Quality Coordinator shall be responsible to support the facility's Performance Improvement/patient safety principles, strategies, priorities, approach, and methodologies, which include but are not limited to the following task:

- ☐ Working with the Medical Staff, patient care and other departments/services, and facilitate the activities of the Quality Council to effectively measure, assess, and improve the quality of care and services.
- ☐ Coordinate Performance Improvement orientation, education, and training.
- ☐ Coach/Facilitate Performance Improvement teams.

**III E ELEMENTS**

**A Measuring performance through standardized data collection and utilization of data measurement to assess current performance:**

***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

Data collected for high priority and required areas are used to monitor the stability of existing processes, identify opportunities for improvements, identify changes that lead to improvement, and sustain the improvement. Data collection helps identify specific areas that require further study. These areas are determined by reviewing the information provided by the data regarding process stability, risks, adverse/sentinel events, and priorities set by leaders. The Surgical Center at Tenaya also identifies those areas in need of improvement and notes desired changes. Performance measures are utilized to determine whether the changes result in desired outcomes. The Surgical Center at Tenaya defines the frequency and detail of data collection. Sources of identifiable problems may include, but are not limited to:

- ☐ Unacceptable or unexpected outcomes of ongoing monitoring of care, such as; complications, hospital transfers, malpractice cases, lack of follow-up on abnormal test results, radiology film retakes, medical errors, medication variances, falls, infections, specific misdiagnoses, near misses, etc.
- ☐ Clinical performance and practice patterns of health care professionals
- ☐ Clinical record review
- ☐ Variances from expected results identified by quality control processes, diagnostic imaging, pathology, medical laboratory and pharmaceutical services.
- ☐ Patient satisfaction surveys
- ☐ Review of Contract services
- ☐ Direct observation of processes and practices
- ☐ Staff concerns
- ☐ Access to care and/or timeliness of services
- ☐ Medical/legal issues
- ☐ Wasteful practices
- ☐ Over-utilization or under-utilization of services
- ☐ Testing of new or enhanced processes or methods of care
- ☐ Benchmarking against best practices

**Utilization Review:** Utilization Review is a formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis. The center provides for the review of center and medical services furnished by the center and medical staff to all patients including those entitled to benefits under the Medicare and Medicaid programs. Criteria that may be included in a complete utilization review include appropriateness of admissions, length of stay, and discharge, appropriateness of pre-op diagnostic testing, a review of drugs and biologicals, accurate ASA classification, appropriate use of anesthesia, a review of block time, case mix and volume by partners and non-partners, and a review of payer mix. Incident reports, medical record reviews, peer review documents, and information system reports will be used to collate this data. After analysis, this information will be reported to the Quality Council and the Governing Body per facility policy and Bylaws on a quarterly basis. The Governing Body shall review the assessed elements of Utilization Review annually and revise as necessary.

**B Specific Measurements Required**

☐ **The facility collects data for priorities identified by leaders**

Identified mandatory quality indicators, determined by facility administrative and medical leadership, will be monitored, measured and trended. These indicators are listed in the medical records review processes and also captured in the outcomes monitoring report. Additional priorities are added as identified by leadership dependent on the scope of service of the facility.

**The facility considers collecting data in the following areas:**

- ❖ Staff opinion and needs

***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

- ❖ Staff perceptions of risks to individuals and suggestions for improving patient safety
- ❖ Staff willingness to report unanticipated adverse events

All of these items are addressed either in the annual employee satisfaction survey, safety culture survey, via an employee suggestion box or via anecdotal information received during teammate meetings.

**□□ The facility collects data on the perceptions of care, treatment, and services of patients including the following:**

- ❖ Their specific needs and expectations
- ❖ How well the facility meets these needs and expectations
- ❖ How the facility can improve safety
- ❖ The effectiveness of pain management, when applicable

All of these items are addressed in the collection of patient satisfaction data via survey or Post-operative follow-up call.

**□□ The facility collects data that measure the performance of each of the following potential high risk processes when applicable:**

- ❖ Medication Management
- ❖ Blood and blood product use, if applicable
- ❖ Operative and other procedure that place patients at risk
- ❖ Infection Control

These items are addressed per Mandatory reporting items

The facility provides ongoing monitoring of important aspects of care provided by the physicians, dentists, and other health professionals. Monitoring of important aspects of care by individual practitioners, as well as practitioners in the aggregate is necessary for monitoring individual performance and establishing internal benchmarks.

Identification of data related to established criteria will be conducted to evaluate and analyze the frequency, severity, and source of the suspected problems or concerns.

Re-measurement of identified trends and/or problems will be conducted to determine objectively whether the corrective actions have achieved and sustained demonstrable improvement. The facility leadership shall be responsible for follow-up on findings of the Quality Council to ensure that effective corrective actions have been taken. Implementation of corrective actions includes but is not limited to:

- ❖ Policy and procedure revisions
- ❖ Updates to facility specific programs/processes, i.e., Infection Control, Medication Management, etc.
- ❖ Education, training and competency updates

Systematic collection and data analysis will be conducted related to identified performance, process and outcomes measures.

Validity and reliability of data is ensured.

Reporting, reviewing and appropriate analysis of all incidents reported by employees, patients, and healthcare professionals and others will be reviewed by the Quality Council, including all deaths, trauma, other adverse events, medical errors, patient complaints, and clinical records/policies.

***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

**Data are systematically aggregated and analyzed** Data related to established criteria are collected in an ongoing manner and are periodically evaluated to identify acceptable or unacceptable trends or occurrences that affect patient outcomes. This is addressed through incident reports and quarterly data collection of mandatory reporting items.

**Data are aggregated at the frequency appropriate to the activity or process being studied** The Surgical Center at Tenaya collects and aggregates (summarizes) data quarterly for mandatory reporting items, while all variances are reported monthly.

**Statistical tools and techniques are used to analyze and display data such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information**

**Data are analyzed and compared internally over time and externally with other sources of information when available**

**Comparative data are used to determine if there is excessive variability or unacceptable levels of performance when available**

**Undesirable patterns or trends in performance are analyzed**

**Analysis is performed when data comparisons indicate that level of performance, patterns or trends vary substantially from those expected** This is addressed via variance and sentinel event reporting on the Quantros System and the facility Quality Council and maintained in the meeting minutes.

**Analysis occurs for those topics chosen by leaders as performance improvement priorities** This is addressed via data collection when reported to the Quality Council.

**Analysis is performed when undesirable variation occurs which changes priorities** This is addressed via variance reporting and data collection when reported to the Quality Council.

**An analysis is performed for the following:**

- ☐ All confirmed transfusion reactions, if applicable
- ☐ All serious adverse drug events, as defined by the facility
- ☐ All adverse patient events and patterns of adverse events during anesthesia use
- ☐ All significant medical and medication errors, as defined by the facility
- ☐ All major discrepancies between preoperative and postoperative (including pathologic) diagnoses
- ☐ Hazardous conditions

These events are addressed via the facility policies on Variance reporting and Root Cause Analysis.

**C. OTHER SPECIFIC MEASUREMENTS**

☐ **Environment of Care**

The Surgical Center at Tenaya monitors conditions in the environment of care

i. The facility establishes and implements processes for reporting the following:

- a. Injuries to patients or others coming to the facility as well as incidents or property damage.
- b. Occupational illnesses and injuries to staff

***The Surgical Center at Tenaya***

**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

- c** Security incidents involving patients, staff or others coming to the facility
- d** Hazardous material and waste spills, exposures and other related incidents
- e** Fire-safety management problems, deficiencies or failures
- f** Equipment management problems, failures and user errors
- g** Utility systems management problems, failures or user errors

- ii** The facility establishes and implements a process for ongoing monitoring or performance regarding actual or potential risks in each of the environment of care management plans.
  - a** Each of the environment of care plans are evaluated at least annually, including the objectives, scope, performance, and effectiveness.
  - b** Environmental safety monitoring and response activities are communicated as required in Leadership.

All of the above items are addressed via the Safety Officer's surveillance and reporting, reported to and evaluated by the Quality Council, MEC, and GB.

- iii.** The facility analyzes identified environmental issues and develops recommendations for resolving them.
  - a** The facility establishes an ongoing process for resolving environment of care issues that involves representatives from clinical, administrative and support services.
  - b** The facility analyzes environment of care issues in a timely manner.
  - c** Recommendations are developed and approved as appropriate.
  - d** Appropriate staff establishes measurement guidelines.
  - e** A recommendation for one or more PI activities is communicated at least annually to the facility's leaders based on the ongoing performance monitoring of the environment of care plans.
  - f** Recommendations for resolving environmental safety issues are communicated to those responsible for managing the patient safety program required in Leadership.
- iv** The facility improves the environment
  - a** Appropriate staff participates in implementing recommendations
  - b** Appropriate staff monitors the effectiveness of the recommendation' implementation
  - c** Monitoring results are reported through the appropriate channels, including the facility's leaders
- v** The facility requires at least four drills per year of the internal emergency plan. One of these must be a documented cardiopulmonary resuscitation technique drill, as appropriate to the facility
  - a** Anesthesia services
  - b** Malignant Hyperthermia drills are performed at least yearly if the facility administers agents known to trigger malignant hyperthermia.

**Management of Human Resources**

- a** Competence to perform job responsibilities is assessed, documented and maintained.
- b** Competence assessment for staff, students and volunteers who work in the same capacity as staff providing care, treatment and services is based on the following:
  - i. Populations served
  - ii. Defined competencies to be required



***The Surgical Center at Tenaya***

**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

- iii. Defined competencies to be addressed during orientation
- iv. Defined competencies that need to be assessed and reassessed on an ongoing basis, based on techniques, procedures, technology, equipment or skills needed to provide care, treatment, and services.
- v. A defined time frame for how often competency assessments are
  - performed for each person, minimally, once in the three year
  - accreditation cycle and in accordance with law and regulation.
- vi. Assessment methods (appropriate to determine the skill being assessed).
- vii. Individuals who assess competency are qualified to do so
- viii. The competence assessment program described is implemented
- ix. When improvement activities lead to a determination that a person with a performance problem is unable or unwilling to improve; the facility modifies the person's job assignment or takes other appropriate action.

All of the above items are addressed via the Education Coordinator's reporting of staff competency scores as well as skills and performance appraisals completed by the supervisor and reported and evaluated at MEC and GB.

- c** Clinical privileges and appointments/reappointments are reviewed and revised at least every two years. The reappraisal addresses current competency and includes the following:

- i. Confirmation of adherence to facility policies, procedures, rules or regulations.
- ii. Relevant information from facility performance improvement activities when evaluating professional performance, judgment, and clinical or technical skills
- iii. Any results of peer review of the individual's clinical performance
- iv. Clinical performance in the facility that is outside acceptable standards

All of the above items are addressed via the Reappointment Review Form that is completed prior to presenting the physician to the MEC for recommendation of reappointment.

**Management of Information**

- a** The facility plans and designs information management processes to meet internal and external information needs.

- i. To guide development of processes for managing information used internally and externally, the facility assesses its information management needs based on the following: its mission, goals, services, staff, patient safety considerations, quality of services, mode of service delivery, resources, access to affordable technology, and identification of barriers to effective communication among caregivers.
- ii. Identified staff participates in assessment, selection, integration and use of information management systems for clinical/service and facility information.
- iii. The facility has an ongoing process to assess the needs of the facility, departments, and individuals for knowledge-based information.
- iv. The facility uses the assessment for knowledge-based as a basis for planning.

- b** The facility has processes in place to effectively manage information, including the capturing, reporting, processing, storing, retrieving, disseminating, and displaying of clinical/service and non-clinical data and information.

- ☐ Quality control systems are used to monitor data content and collection activities:

***The Surgical Center at Tenaya***

**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

- ❖ The method used provides for timely and economical collection of data with the degree of accuracy, completeness, and discrimination necessary for the intended use.
- ❖ The method used minimizes bias in the data and regularly assesses the data's reliability, validity, and accuracy
- ❖ Those responsible for collecting, reviewing the data are accountable for information accuracy and completeness
- ☐ Data and information are retained for sufficient time to comply with law or regulation
- ☐ Knowledgeable staff and tools are available for collecting, retrieving and analyzing data and their transformation into information
- ☐ Data are organized and transformed into information formats useful to decision makers
- ☐ Dissemination of data and information is timely and accurate
- ☐ Data and information are disseminated in standard formats and methods to meet user needs and provide for retrievability and interpretation
- c** ☐ The facility has a complete and accurate medical record for every individual assessed or treated.
  - ☐ Medical records are reviewed on an ongoing basis
  - ☐ The review of medical records is based on facility-defined indicators that address the presence, timeliness, readability (whether hand written or printed), quality, consistency, clarity, accuracy, completeness, and authentication of data and information contained within the record.

The above items are addressed via the Business Office Medical Record Completion Checklist and the Facility Medical Record/Peer Review Policy and are reported to the Quality Council and to MEC/GB as appropriate.

**☐ Surveillance/Prevention and Control of Infection**

- a** ☐ The Infection Control Program identifies risks for the acquisition and transmission of infectious agents on an ongoing basis.
- i** ☐ The facility identifies risks for the transmission and acquisition of infectious agents throughout the facility based on the following factors:
  - ❖ Geographic location and community environment of the facility, program/services provided, and the characteristics of the population served.
  - ❖ The results of the analysis of the facility's infection prevention and control data
  - ❖ The services provided
- ii** ☐ The risk analysis is formally reviewed at least annually and whenever significant changes occur.
- iii** ☐ Surveillance activities, including data collection and analysis, are used to identify infection prevention and control risks pertaining to patients, LIP's, staff, volunteers, and students/trainees, visitors, and families.
- b** ☐ The infection control program evaluates the effectiveness of the infection control interventions and, as necessary, redesigns the infection control interventions.

The facility formally evaluates and revises the goals and program at least annually and whenever risks significantly change.

These items are addressed per the facility PI and Infection Control Program.
- c** ☐ Infections are reported, when appropriate, within the facility, to the

***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

organization's home office, and/or to public health agencies.

i The facility reports infections internally as appropriate.

ii Results of the infection control program are reported to appropriate authorities as required by law, regulation and facility policy.

These items are addressed per the facility Performance and Quality Improvement and Infection Control Program.

See also SCA Risk Management Policy RMT-03-111, Infection Control Program.

**Adverse Events**

Leadership establishes processes for the identification, reporting, analysis, and prevention of adverse patient incidents and ensuring their consistent and effective implementation by developing a system that includes:

a A definition of adverse incidents that includes unexpected occurrences 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; any process variation for which a recurrence carries a significant chance of a serious adverse outcome.

b A process for conducting a thorough analysis

c A process for reporting adverse incidents through established channels within the facility and, as appropriate, to external agencies in accordance with law and regulation.

d An action plan that identifies the strategies that the facility intends to implement to reduce the risk of a similar event occurring in the future.

e An evaluation of the improvements to ensure they are sustained over time.

f Educating staff to ensure their familiarity with the implemented strategies.

See also SCA Risk Management Policy RMT-02-103, Root Cause Analysis/Sentinel Events Policy.

**Patient Satisfaction**

The facility periodically assesses patient satisfaction with services provided to patients by the facility.

**Medication Management**

The Medication Management program establishes processes to identify risks and achieve a reduction and/or proactive elimination of medication related errors within the surgery center.

See SCA Medication Safety Plan

**Pathology and Medical Laboratory Services**

Performing and documenting appropriate quality control procedures, including, but not limited to, calibrating equipment periodically and validating test results.

**SPECIFIC MEASURES GUIDELINE**

The facility's Performance Improvement Plan uses appropriate statistical techniques for data measurement and analysis. The assessment of the Performance and Quality Improvement/Patient Safety Plan shall include at the minimum the following:

Comparison of data over time

Comparison with practice guidelines in the literature and expert opinions

Comparison to external data bases

Comparison to internal data bases

Intensive assessment will occur in the following cases:

**The Surgical Center at Tenaya**  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

- ☐ When there is undesirable variation
- ☐ When there is a sentinel event that triggers concern

**EXAMPLE MANDATORY MEASUREMENTS**

MEASUREMENT	FREQUENCY OF REPORTING AND ANALYSIS
1. Patient Satisfaction	Qtrly
2. Medication Management per Risk Management Policies RMT-02-110; RMT-02-111; RMT-05-105	Qtrly
3. Blood and Blood Product Use if applicable	Qtrly
4. Confirmed Transfusion Reactions	Qtrly
5. Operative or other Procedures that place patients at risk per Risk Management Policies RMT-02-108; RMT-02-109	Qtrly
6. Major discrepancies between pre and post operative diagnosis (including pathology)	Qtrly
7. Adverse events during moderate or deep sedation and anesthesia	Qtrly
8. Autopsy Results	Qtrly
8. Injury to patients or others at the facility	Qtrly
9. Property Damage	Qtrly
10. Occupational illness and injury to staff	Qtrly/Annually
11. Security Incidents involving anyone in the facility or on the property	Qtrly
12. Hazardous materials and waste spills, exposures and related incidents	Qtrly
13. Fire-safety management failures and user errors	Qtrly
14. Equipment failures and user errors	Qtrly
15. Utility systems failures and user errors	Qtrly
16. Medical Record/Peer Review	Qtrly
17. Off site patient care services (lab, radiology, pharmacy, etc.)	Qtrly
18. Infection Control	Qtrly
19. Staff competence assessment and learning needs	Annually
20. The development of new services/programs	Annually
21. Leadership effectiveness of their contributions to improving performance	Annually
22. Clinical Privileges/Practice Prerogatives	Bi-Annually
23. Malignant Hyperthermia drill	Annually
24. Fire Drills	Quarterly
25. Annual Performance/Quality Improvement/Safety Plan Evaluation	Annually

**IDENTIFYING AND MANAGING OPPORTUNITIES FOR IMPROVEMENT**

**A.** The Quality Council will review and analyze data to identify opportunities for improvement. Opportunities for improvement may also result from meaningful feedback submitted by teammates or providers. This feedback is documented on the Opportunity for Improvement Form (OFI) and submitted to the Quality Council for review. The following questions should be addressed when identifying improvement opportunities. Does it:

- Improve quality
- Respond to a new directive
- Support the strategic goals
- Respond to complaints

***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

- Address problems
- Address readiness issues
- Address resource issues
- Respond to external competition
- Respond to new trends
- Respond to new technology
- Respond to change in mission
- Address accreditation or regulatory requirements
- Other

**B** Facility leadership (Administrative, Clinical, MEC and GB) prioritizes performance improvement activities reported up through Facility Quality Council to MEC and GB. Priorities are set for performance improvement, considering the prevalence and severity of identified problems, and priority given to improvement activities that affect patient safety, clinical outcomes and quality of care. A determination of which improvement to pursue is done through a priority grid that measures each improvement opportunity against established criterion.

A new process/service is designed or the current process design is analyzed to identify key variables in the process and opportunities to simplify. The process must be cost-effective, defect free and operate at a very high level of performance. Criteria for designing new processes and services and/or the indicated improvement of existing processes or services shall be based on the following assessment:

- ☐ Is it consistent with the facility/center mission, vision and resources (human, financial and physical)
- ☐ Is the area targeted for improvement a high risk, high volume or problem prone process
- ☐ Are the needs and expectations of all customers (patients, staff, community, MDs, payors and others) considered
- ☐ Is the design or improvement effort based upon up-to-date sources of information (common practice guidelines, professional literature, and the input of experts in the field)
- ☐ Is the performance of the processes and its outcomes in other organizations (external databases) used to provide information on performance as it relates to peers in the industry
- ☐ Has the process been developed with input from all relevant sources
- ☐ Has the process been approved by the Quality Council, Medical Executive Committee and Governing Body

**C** A multidisciplinary team is identified to implement the new or redesigned process. A facilitator from the Quality Council will ensure there is common understanding and project agreement among the Performance Improvement team members. The Performance Improvement team includes members who have a level of shared knowledge about the task and are familiar with all the different parts of the process — managers and administrators as well as those who work in the process, including physicians, nurses, and front-line workers. **CAUTION: DO NOT “elevate” and issue to a PI team if it can be easily resolved by normal operational decisions** These easily resolved performance improvement activities are documented utilizing the Quick Fix Project form.

The PI team collects data and assesses it in order to determine:

- ☐ Whether intended specifications for new processes are met.

***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

- ☐ The level of performance stability of existing important processes.
- ☐ The priorities for improving existing processes.
- ☐ Actions to improve the performance of processes.
- ☐ Whether changes in the processes resulted in improvement.
- ☐ Special causes vs. common cause variation.
- ☐ Patient Safety is being addressed

**B** The Performance Improvement Team will complete a Performance Improvement Update prior to each facility Quality Council Meeting to keep the council abreast of the project's progress.

**C** The facility Quality Council shall direct the implementation of changes that are identified through Performance Improvement Teams and Leadership recommendations. These improvements shall have the following characteristics:

- ☐ May use trial basis/pilot project for implementation and to determine effectiveness of solution: if solutions are not effective, other solutions are then developed/tried.
- ☐ The effect of the improvement is assessed, and if there is success it is implemented facility wide as appropriate.
- ☐ Improvement efforts shall be directed at processes, not individuals. However, if an individual has performance problems that he or she is unable or unwilling to improve, his or her clinical privileges or job assignment are modified, as indicated, or other appropriate action will be taken via medical staff peer review, or according to the contractual terms, or departmental Human Resource policies.

**D** All performance improvement activities are reported up to the Governing Body. The leadership allocates adequate resources for improvement and assures that all teammates are trained and educated about assessing and improving processes that contribute to improved facility outcomes. Leadership fosters communication among individuals and components of the organization to improve the coordination of activities.

***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

**Clinical Practice Guideline Development Resource Sheet**

**Remember some of the goals for developing CPGs:**

- Reducing Variation and probability of Adverse Events.
- Providing a specific standard of care to enhance patient safety and outcomes.
- Allowing for specific outcomes monitoring and benchmarking of best practices.

**Guide for developing CPGs:**

**CPGs are used in designing or improving processes that evaluate and treat specific diagnoses/conditions and/or symptoms**

- Make sure you define specifically what you are designing and/or improving. What is your mission?
- What did you identify in your literature review of evidence-based practice that led you to design and/or improve this process?
- What is your baseline data? Did you collect data retrospectively from Medical Records and/or develop a tool to complete an initial assessment of the current situation? What % of negative outcomes have you had specific to the process you are addressing? What % of MD compliance do you have initially (before implementation of the CPG)? Do certain MDs have better outcomes than others with respect to your identified process (before implementation of the CPG)?
- Make sure you identify SPECIFICALLY what you are taking from your baseline data and evidence-based literature and applying to develop your CPG **and why**.

**The ASC's leaders identify criteria for the selection and implementation of CPGs**

- You should be reviewing your facility's Scope of Service and your Approved Procedure List to identify high volume, high risk and problem prone procedures in your center. You should be addressing CPGs that affect those populations first.
- Remember to note your baseline data as part of the criteria that helped you choose to implement this particular CPG.
- Once you complete your literature review and initial assessment (Baseline data) and you have determined what process changes you will implement, make SURE you specify a quantitative goal for improvement/compliance. (What % compliance do you expect from MDs? What % reduction in negative outcomes do you expect initially?)

**Appropriate leaders/practitioners and healthcare professionals in the organization review and approve the CPG selected for implementation**

- Who is involved in the design/implementation of this CPG? Make sure you have a multidisciplinary team identified with physicians included. Make sure it is well-documented throughout your project (minutes, etc) so that it is obvious that this was a joint effort in design and approval.

**Leaders evaluate the outcomes related to the use of CPGs and refine guidelines to improve processes**

***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

- After you complete your initial assessment (baseline data) and implement your CPG, did you develop some tool to review compliance/success with your CPG i.e. How are you monitoring the success of your implementation so you will have data to compare with your baseline? Is that comparison data being reported at QC and MEC to meet the standard? Are you tying MD compliance to your CPG with patient outcomes and utilizing this in the reappointment review?
- If the literature changes regarding your guideline, are you updating the process as time passes?

**Implementation of Clinical Practice Guidelines to improve quality and reduce variation of care in specific diagnoses/conditions or symptoms**

A clinical practice guideline (CPG) can improve the quality utilization and value of healthcare services. CPGs help practitioners make decisions about the prevention, diagnosis, treatment and management of specific conditions. Facility leadership must identify, select and implement CPGs appropriate to the patient populations served. CPGs must be approved by the facility leadership and monitored for compliance after implementation.

**A CPG provides an effective way to improve process(es) by reducing variation** This is not to say that there will never be variation. The variation should, however, be evaluated to better manage the process/procedure/ practice.

- ☐ Administrative and Clinical (MEC) Leadership will discuss the most appropriate processes, procedures or diagnoses based on services provided at the facility (Scope of Services and approved procedure list to be reviewed). Review only one process, procedure or diagnosis at a time prioritize using high volume, high risk or problem prone areas.
- ☐ Review clinical practice guidelines for the chosen project via literature review.
- ☐ Leaders will apply the PI Priority Grid to the procedures and diagnoses identified in step one to identify the CPG that scores the highest.
- ☐ The leaders will then identify an appropriate team to develop the first CPG with an identified time frame for development and chairperson.

**Required documentation for CPG:**

Data (as applicable) to support the need for the CPG (consider a report similar to the PI project summary report).

Literature (as applicable) to support the published best practice used in the CPG

Priority key if more than one CPG is considered

Meeting minutes demonstrating discussion and decisions related to the CPG, both of the Quality Council and MEC/Governing body.

CPG document or statement (it is encouraged to keep CPG's separate from policies and not write a CPG up as a policy).

**In summary:** Accreditation standards require that CPG's are implemented but the frequency is not defined. For CPG's in place, monitor for effectiveness and revise (update) as applicable. Annually look for opportunities to implement a new CPG. It should be the result of identifying some variability or lack of a standardized/best practice process in the facility. CPG's commonly result from a PI project or a publicly identified patient safety issue. The MEC looks at, considers,



***The Surgical Center at Tenaya***  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**

and makes a decision to implement or not and the discussion and decision is documented in the minutes.

Educate and monitor for compliance

**Implementation of a Facility-Specific Patient Safety Program**

Facility leadership facilitates a safe environment by ensuring that safety priorities are integrated into all applicable processes in the organization. Each component of the Performance Improvement Plan compliments the Patient Safety Program by reducing the risk of process failures via performance improvement projects, and clinical practice guidelines. Implementation of the National Patient Safety Goals (NPSGs), the Universal Protocol for Prevention of Wrong Site, Wrong Person and Wrong Procedure Surgery and evaluation and review of Sentinel Event Alerts offer additional value to the Facility Patient Safety Program.

The patient safety program includes the following:

- ☐ Management of the program by the Facility Quality Council and additional employees as indicated
- ☐ Oversight of unanticipated events whether they be no harm, near miss or actual Sentinel Events
- ☐ Assurance by the Facility Quality Council to integrate the Patient Safety Program into all elements of the Facility
- ☐ Processes to immediately respond to systems failures including caring for involved individuals, reducing the risk to others and ensuring complete, accurate documentation of the event for analysis
- ☐ Clear processes for reporting information regarding unanticipated events or process failures
- ☐ Standardized process for responding to unanticipated adverse events
- ☐ Provision of support for employees involved in a sentinel event
- ☐ Scheduled annual reporting to the MEC and GB related to unanticipated events, system failures, and safety improvements made within the Facility

*The Surgical Center at Tenaya*  
**PERFORMANCE/QUALITY IMPROVEMENT and PATIENT SAFETY PLAN**



## **PATIENT SAFETY PLAN 2016**

### **PLAN PURPOSE**

The SMA Patient Safety Plan is designed to improve patient safety, reduce risk and respect the dignity of those we serve by assuring a safe environment

Recognizing that effective medical/health care error reduction requires an integrated and coordinated approach, the Patient Safety Plan relates specifically to a system-wide program to minimize physical injury, errors, accidents and undue psychological stress during patient care

The organization-wide patient safety program will include all activities contributing to the maintenance and improvement of patient safety

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

### **PLAN OBJECTIVES**

The objectives of the Patient Safety Plan are to:

- 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

### **PATIENT SAFETY COMMITTEE**

#### **1 Charter**

- 1.1** The Patient Safety Committee (hereinafter, the "Committee") is a standing confidential interdisciplinary review committee formed pursuant to N.R.S. § 49.117 and 42 U.S.C. § 11151 that manages the organization's Patient Safety Program and Infection Prevention and Control Program through a systematic, coordinated, continuous approach
- 1.2** The Committee has the responsibility of evaluating and improving the quality of care rendered by the organization
- 1.3** The Committee 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

#### **2 Chair**

- 2.1** The designated SMA Patient Safety Officer will chair the Patient Safety Committee

#### **3 Committee Membership**

- 3.1** Committee membership includes services involved in providing patient care, including but not limited to the Patient Safety Officer, the Infection Control Officer, at least three members of the Medical Staff, Nursing, at least one member of the Executive Staff, Pharmacy, Ambulatory Surgery, Legal, Compliance, Risk Management, Infection Prevention, Safety and Compliance

#### **4 Scope**

- 4.1** The scope of the Patient Safety Committee includes all patient safety activities including infection control activities, oversight of initiatives to promote patient safety and monitoring and review of medical/healthcare errors/potential errors involving patients, visitors, SMA staff, students and volunteers
- 4.2** The Patient Safety Committee will evaluate aggregate data/processes and limited specific clinical details related to individual occurrences in order to utilize performance improvement methodologies to promote patient safety and infection prevention
- 4.3** The Patient Safety Committee works in partnership with but does not replace the work of other quality committees and/or established medical staff peer review processes

#### **5 Organizational Integration**

- 5.1** The mechanism to insure all components of the organization are integrated into the patient safety program is through a collaborative effort of multiple disciplines. This is accomplished by:
  - Reporting potential or actual occurrences through the Incident Occurrence Reporting Policy (SMA Policy # 190-4) by any employee in every department
  - Communicating effectively between the Patient Safety Officer/Patient Safety Committee and the UHG Safety Liaison to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment
  - Reporting patient safety and operational safety measurements/activity to the Quality Management Committee and the Board of Directors

#### **6 Data Collection**

- 6.1** The Patient Safety Committee will utilize aggregate data from internal sources (information systems data collection, incident reports and questionnaires) and external sources (National Healthcare Safety Network-NHSN, and evidence-based medicine) for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness

#### **7. Safety Measures**

- 7.1** The Patient Safety Committee will focus patient safety activities on patient safety measures including:
  - Laboratory Services
  - Emergency Equipment and Response
  - Medication Administration Process
  - Infection Prevention
  - National Patient Safety Goals
  - Environment/Equipment
  - Confidentiality and Privacy
  - Medical Record Documentation
  - Clinical Practice
  - Sterilization and High Level disinfection
  - Adverse Incidents
  - Sentinel Event Reports
- 7.2** The Committee will utilize severity categories for medical healthcare errors/healthcare acquired infections. The severity categories of medical/health care errors include:
  - No Harm Error: An unintended act, either of omission or commission, or an act that does not achieve its intended outcome
  - Mild to Moderate Adverse Outcome: Any set of circumstances that do not achieve the desired outcome and result in a mild to moderate physical or psychological adverse patient outcome
  - 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
  - Sentinel Event: 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. In Nevada, reportable sentinel events are those events contained in the National Quality Forum's *Serious Reportable Events in Healthcare*
- 7.3** The Patient Safety Committee shall adopt patient safety checklists and policies for use by providers and personnel as well as for employees whose duties affect the health or welfare of the patients (See N.R.S. § 439.877(1))

#### **8 Infection Prevention Measures**

- 8.1** The Patient Safety Committee will focus on infection prevention measures including:

- Occurrence of infections
- Severity of infections

**8.2** The Patient Safety Committee/Infection Prevention officer will:

- Take action as necessary to prevent and control infections
- Carry out provisions of an infection control program (NRS 439.865) and ensure compliance with the program

**9 Measurements**

- 9.1** The Patient Safety Committee will determine standardized defined measurements for patient safety measures through mechanisms such as the CDC National Healthcare Surveillance Network and established national standards
- 9.2** Staff will report this aggregate data to the Patient Safety Committee at regularly scheduled intervals

**10 Process Analysis**

- 10.1** The Surgery Center (SSC), 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
- 10.2** For the quality studies, the SSC may base the selection on information published by accrediting bodies, the 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
- 10.3** The Patient Safety Committee will approve the selected process and support the SSC quality studies
- 10.4** The SSC quality studies will focus in 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

**PATIENT SAFETY OFFICER**

**11 Patient Safety Officer**

- 11.1** The Patient Safety Officer will be the liaison to the SSC Leadership, other quality committees and the Board of Directors

**12 Responsibilities**

- 12.1** The responsibilities of the Patient Safety Officer include:
- Chair the Patient Safety Committee
  - Supervise the reporting of all sentinel events alleged to have occurred at the facility including but not limited to performing any duties required by N.R.S. § 439.835
  - Take any action deemed necessary by the Patient Safety Officer to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility
  - Report any action to the Patient Safety Committee taken in response to alleged sentinel events

- Compliance with patient safety standards and initiatives
- Reinforcement of the expectations of the Patient Safety Plan
- Acceptance of accountability for measurably improving safety and reducing errors

**12.2** These duties may include soliciting employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences and immediate response to reports concerning workplace conditions

### **13 Discussion with the Patient/Family/Caregivers Regarding Adverse Outcomes**

**13.1** Events impacting the patient's clinical condition:

- The Patient Safety Officer will notify the care-giving physician about informing the patient/family/caregivers in a timely fashion (within 48-72 hours)
- Should the care-giving physician refuse or decline communication with the patient/family/caregivers, the Patient Safety Officer will notify the SMA President
- Staff will not contact the patient/family/caregivers without the permission and/or notification of the care-giving physician
- The care-giving physician will determine the appropriateness of documentation of the occurrence in the medical record and will communicate this to the Patient Safety Officer

**13.2** Events NOT impacting the patient clinical condition, but causing a delay or inconvenience:

- The Patient Safety Officer will communicate the need for communication with the patient/family/caregiver to the Chief Nursing Officer/Clinical Leadership of the appropriate division.

### **INFECTION CONTROL OFFICER**

#### **14 Infection Control Officer**

**14.1** The Infection Control Officer will serve on the Patient Safety Committee and will be the liaison to other quality committees and the Board of Directors

**14.2** The Infection Control Officer shall be a certified infection preventionist or must complete a nationally recognized basic training program in infection control

#### **15 Responsibilities**

**15.1** The responsibilities of the Infection Prevention Officer include:

- Monitor the occurrences of infections and determine the number and severity of infections
- Report to the Patient Safety Committee the number and severity of infections at the facility
- Take such action as deemed 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 N.R.S. § 439.865
- Ensuring compliance with current infection prevention and control standards
- Directing infection prevention initiatives
- Reinforcement of the 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
- Provide medical direction as indicated (for both patient and employee infection control issues)

#### **16 Educational Requirements**

**16.1** The Infection Control Officer will complete at least four hours of continuing education each year on topics related to current practices in infection control and prevention

#### **17 Infection Prevention Coverage**

**17.1** The Infection Control Officer will designate a person to be responsible for infection control when the Infection Control Officer is absent to ensure someone is responsible for infection prevention at all times

### **RN INFECTION CONTROL PREVENTIONIST**

#### **18 Infection Control Preventionist RN**

**18.1** SMA will maintain at least one employee (Registered Nurse) with training and education in infection prevention and control

**18.2** While supporting the entire organization, the Infection Control Preventionist RN will dedicate specific hours to the SSC

### **INFECTION CONTROL PROGRAM**

#### **19 The Infection Control Program**

**19.1** The Infection Control Program and the SSC Infection Control Program (SSC 1600-3 Infection Control Program for Southwest Medical Associates Surgery Center) are components of the Patient Safety Plan

- 19.2 The purpose of the Infection Control Programs is to prevent and control infections
- 19.3 The Infection Control Programs are based on current guidelines developed by nationally recognized infection control organizations
- 19.4 The Infection Control Professionals will report regularly on the number and severity of infections that occurred in the prior quarter

#### **RESPONSE TO MEDICAL/HEALTH CARE ERROR**

##### **20 Immediate Response to Medical/Health Care Error**

- 20.1 Staff will immediately report the event to supervisor
- 20.2 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
- 20.3 Staff will complete the Incident/Occurrence Report or Quality of Care form
- 20.4 Staff will obtain required orders to support the patient's clinical condition
- 20.5 Staff will notify the UHG Safety Liaison of any situations of potential risk to others
- 20.6 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

##### **21 Identification and Reporting**

- 21.1 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
- 21.2 The organization will incorporate willingness to report medical errors into annual staff surveys to measure the willingness of staff to report and will support a Just culture that focuses on process not individuals

##### **22 Root Cause Analysis**

- 22.1 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
- 22.2 The Patient Safety Officer will act as the liaison to quality committees and the Board of Directors for review/recommendations

##### **23 Staff Involvement**

- 23.1 As this organization 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**

##### **24 Sentinel Event Reporting**

- 24.1 The Patient Safety Officer will report sentinel events to the Patient Safety Committee  
The Patient Safety Officer will also 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)
- 24.2 The Patient Safety Officer will also report the number of sentinel events and recommendations to reduce the number or severity of sentinel events to the SMA Board of Directors
- 24.3 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
- 24.4 The Patient Safety Committee shall evaluate the actions of the Patient Safety Officer in connection with the reporting of sentinel events
- 24.5 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

##### **25 HealthCare Acquired Infections (HAI) Reporting**

- 25.1 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
- 25.2 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

**25.3** 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

**26 Internal Reporting**

**26.1** 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 quality committees and the SMA Board of Directors

**26.2** The Patient Safety Committee will include ongoing activities such as data collection and analysis, actions taken and monitoring for the effectiveness of actions

**27 External Reporting**

**27.1** The Patient Safety Committee will report externally in accordance with all state, federal and regulatory body rules, regulations and requirements.

**27.2** 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

**27.3** The SSC will participate in the CDC National Healthcare Surveillance Network per State of Nevada NRS and NAC

**28 Annual Report**

**28.1** 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 the results of the program that assesses and improves 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

**29 Medical Facility (SSC) Reporting Requirements**

**29.1** 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

**30 Public Disclosure**

**30.1** The SSC will provide the name of each physician who performed a surgical procedure at the SSC, 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)

**PATIENT AND FAMILY INVOLVEMENT**

**31 Patient and Family**

**31.1** The organization will accomplish solicitation of input and participation from patients and families in improving patient safety by:

- Conversations with patients and families during care (example = discharge instructions)
- During patient call-backs from SSC staff
- Comments from Patient Satisfaction surveys

**31.2** The organization will communicate with patients/families regarding the organization's role and commitment to meet the patient's right to have unexpected outcomes or adverse events explained in an appropriate, timely fashion through:

- Patient rights



- Patient responsibilities (a list of patient responsibilities will be included in the admission information booklet. These responsibilities include the patient providing correct information about perceived risks and changes in their condition, asking questions, following instructions, accepting consequences, following facility rules, etc.)
- 31.3** SMA will post a notice in every exam room that informs the patient of the right to have the reasons for a prescription medication included on the medication label

#### **STAFF COMPETENCE**

### **32 Competence**

- 32.1** Methods to assure ongoing in-services, education and training programs for process improvement and support of an interdisciplinary approach to patient care will include:
- Providing education regarding reporting mechanisms to new staff in the orientation period
  - Providing ongoing education, including regarding reporting mechanisms, through information presented in LearnSource and other instructional venues including clinical sites
  - Obtaining a confidential assessment of staff's willingness to report medical errors at least annually
  - Testing staff knowledge regarding patient safety

#### **PATIENT SAFETY INITIATIVES**

### **33 Patient Safety Initiatives**

- 33.1** The Patient Safety Committee will provide oversight in the development of a policy for use of nationally recognized standard precautionary protocols to be observed by providers and staff including protocols related to hand hygiene
- 33.2** The Patient Safety Committee shall adopt a policy for appropriately identifying a patient before providing treatment; the policy shall require the patient to be identified with at least two personal identifiers before each interaction with a provider
- 33.3** The Patient Safety Committee will provide oversight in the development of a policy for use of patient safety checklists and polices that include active surveillance of compliance (active surveillance may include a system for reporting violations, peer to peer communications, and audits)
- 33.4** The Patient Safety Committee will monitor and document the effectiveness of the patient identification policy.
- 33.5** The Patient Safety Committee will review and/or revise the patient safety checklists and patient safety polices and consider any additional patient safety policies as indicated or appropriate (to ensure the checklist and/or policy reflects the most current standards in patient safety)
- 33.6** The Patient Safety Committee will provide oversight in adherence to safe injection practices
- 33.7** The Patient Safety Committee will monitor and document the effectiveness of the safe injection practices education via the performance improvement process
- 33.8** The Patient Safety Committee will develop a LearnSource course on Patient Safety, that includes education on the most current components of the Patient Safety Plan; SMA employees will complete the course as part of initial orientation

#### **HEALTH CARE ACQUIRED INFECTIONS (HAIs)**

### **34 Health Care Acquired Infections (HAIs)**

- 34.1** SSC (a medical facility) will provide general and facility specific information related to facility acquired infections to each patient upon admission including:
- The measures used for preventing infections, including facility acquired infections
  - Information on determining whether a patient had an infection on admission
  - Risk factors for acquiring infection and determining whether an infection has been acquired
  - Information on preventing facility acquired infections
  - Instructions for reporting facility acquired infections, including, without limitations, the contact information for making reports to the Health Division
  - Any other information the SSC deems necessary
- 34.2** SSC (a medical facility) will post, in a publically accessible area, information regarding:
- Reporting facility acquired infections
  - The contact information for making reports to the Health Division

#### **CONFIDENTIALITY**

### **36 Confidentiality**

- 36.1** All information related to organizational patient safety performance improvement activities performed by the medical staff or SMA personnel in accordance with the Patient Safety Plan is confidential and is protected by the NRS 439.805
- 36.2** Confidential information may include, but is not limited to, Patient Safety Committee minutes; any associated medical staff

committee minutes, organizational performance improvement reports, electronic data gathering and reporting and incident reporting

- 36.3** The Patient Safety Committee may disseminate some information as required by agencies such as federal review agencies, regulatory bodies or any individual or agency that proves a “need to know” as approved by SMA Administration and/or the SMA Board of Directors

#### **PLAN EVALUATION/APPROVAL**

**37 Evaluation and Approval**

**37.1** The Patient Safety Committee will review, evaluate and update the plan at least annually and as needed

**37.2** The Patient Safety Committee/Patient Safety Officer will report plan revision, and update to the SMA Board of Directors

**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 1/2016

**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 Control in Reprocessing of Flexible Gastrointestinal Endoscopes 2015
- c. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Guideline for Use of High Level Disinfectants and Sterilants for Reprocessing Flexible Gastrointestinal Endoscopes 2013
- d. American Society for Gastrointestinal Endoscopy (ASGE) Infection Control during GI Endoscopy 2008
- e. Center for Disease Control (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007
- f. CDC Guide to Infection Prevention for Outpatient Settings 2014
- g. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the Elimination of Clostridium difficile in Healthcare Settings 2013
- h. 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
- f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

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.

*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.*

- 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 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.

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.

*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.*

- 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.

*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.*

Section 3 Safety Management	Smoke Ranch Surgery Center	
Policy Name: <b>PATIENT SAFETY GOALS</b>		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: <b>PATIENT SAFETY GOALS</b>		Page 1 of 3
Approved: <b>JAN 27 2010</b>	Revised: <b>FEB 01 2011</b>	

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: <b>PATIENT SAFETY GOALS</b>	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: <b>PATIENT SAFETY IN THE OPERATING ROOM</b>	Page 1 of 4	
Approved: <b>JAN 27 2010</b>	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*

Section 3 Safety Management	Smoke Ranch Surgery Center
Policy Name: <b>PATIENT SAFETY IN THE OPERATING ROOM</b>	Page 2 of 4

- 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.

Section 3 Safety Management	Smoke Ranch Surgery Center
Policy Name: <b>PATIENT SAFETY IN THE OPERATING ROOM</b>	Page 3 of 4

- 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.

## **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.



MANUAL: Policy and Procedure

SECTION: 12 Life Safety Management Plan

POLICY: 12.11 Patient Safety Program

=====

**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.



POLICY: 12.11 Patient Safety Program

=====

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 where necessary.
      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.



POLICY: 12.11 Patient Safety Program

=====

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. Nurses follow safe standards of practice identifying the drug, dose, route, time, patient's name and all allergies before administering medications.
  9. 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.





MANUAL: Policy and Procedure

SECTION: 12 Life Safety Management Plan

POLICY: 12.11 Patient Safety Program

=====

- 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- Life Safety Management Plan

## SIERRA CENTER FOR FOOT SURGERY

### **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 following pages in the form of the center's policy's and procedures relating to patient safety.

The Sierra Center for Foot Surgery has designated Name has been removed based on NRS439.843. 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 every calendar quarter.

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.

<b>SHSC</b>	<b>SIENA HEIGHTS SURGERY CENTER</b>		
	<small>ORIGINAL DATE</small> October 2014	<small>REVISED DATE</small>	<small>PAGE NUMBER</small> 1 of 2
	<small>SUBJECT</small> <b>SAFETY PROGRAM</b>		<small>ADMINISTRATOR</small> Name has been removed base on NRS439.843. <small>MEDICAL DIRECTOR</small> Name has been removed base on NRS439.843.
<small>POLICY NUMBER</small> 9-20			

**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.

**RECEIVED**

**APR 13 2016**

Nevada State Health Division  
EPIDEMIOLOGY PROGRAM

<b>SHSC</b>	<b>SIENA HEIGHTS SURGERY CENTER</b>		
	<small>ORIGINAL DATE</small> October 2014	<small>REVISED DATE</small>	<small>PAGE NUMBER</small> 2 of 2
	<small>SUBJECT:</small> <b>SAFETY PROGRAM</b>		<small>ADMINISTRATOR</small> Name has been removed base on NRS439.843.  <small>MEDICAL DIRECTOR</small> Name has been removed base on NRS439.843.
<small>POLICY NUMBER</small> 9-20			

- 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. /

**RECEIVED**

**APR 13 2016**

Nevada State Health Division  
EPIDEMIOLOGY PROGRAM

<b>Policy Title:</b>	<b>SAFETY Management Plan</b>		
<b>Approved:</b>	<b>2/19/2013</b>	<b>Page:</b>	<b>1 of 2</b>
<b>Effective:</b>	<b>2/28/2013</b>	<b>Retired:</b>	

**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

<b>Policy Type:</b>	<b>FE_FACILITIES - ENVIRONMENT</b>
<b>Center:</b>	<b>Las Vegas East Eye</b>
<b>Center DBA:</b>	<b>Shepherd Eye Surgicenter</b>

<b>Policy Title: SAFETY Management Plan</b>	
<b>Approved: 2/19/2013</b>	<b>Page: 2 of 2</b>
<b>Effective: 2/28/2013</b>	<b>Retired:</b>

- 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.

<b>Policy Type:</b>	<b>FE_FACILITIES - ENVIRONMENT</b>
<b>Center:</b>	<b>Las Vegas East Eye</b>
<b>Center DBA:</b>	<b>Shepherd Eye Surgicenter</b>

# SEVEN HILLS SURGERY CENTER

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 1 OF: 10
	EFFECTIVE:
APPROVED BY: Board of Managers	REVISED: 2/2010km

## **PURPOSE:**

- The purpose of the organizational Patient Safety Plan at Seven Hills Surgery 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 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 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 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 Seven Hills Surgery Center. The Patient Safety Plan outlines the components of the organizational Patient Safety Program.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 2 OF: 10
	EFFECTIVE:
APPROVED BY: Board of Managers	REVISED: 2/2010km

## **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 Quality Assurance 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
    - 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.



SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 3 OF: 10
	EFFECTIVE:
APPROVED BY: Board of Managers	REVISED: 2/2010km

- 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):
    - Abduction of any patient receiving care
    - Infant abduction or discharge to the wrong family
    - Rape (by another patient, visitor or staff)
    - Surgery or invasive procedure performed on the incorrect patient or incorrect body part
    - The unintentional retention of a foreign object, i.e., sponge, instrument, in a postoperative or postinvasive procedure patient
    - All identified cases of unanticipated death or major permanent loss of function associated with a healthcare associated infection
    - 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
- 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.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 4 OF: 10
	EFFECTIVE:
APPROVED BY: Board of Managers	REVISED: 2/2010km

- 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:
  - 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 Quality Assurance
  - Management of Human Resources
  - Management of Information

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 5 OF: 10
	EFFECTIVE:
APPROVED BY: Board of Managers	REVISED: 2/2010km

- Methodology:
  - The Quality Assurance Committee is responsible for the oversight of the Patient Safety Program.
  - **All departments** within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Quality Assurance Committee, who will aggregate occurrence information and create a report on a quarterly 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 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, Joint Commission sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from state and federal sources and current literature), the Quality Assurance 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

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 6 OF: 10
	EFFECTIVE:
APPROVED BY: Board of Managers	REVISED: 2/2010km

- 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 - 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.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 7 OF: 10
	EFFECTIVE:
APPROVED BY: Board of Managers	REVISED: 2/2010km

- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- 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 administrator.
- 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 Administration 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 Quality Assurance Committee.
    - ◆ Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will notify Administration 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 Quality Assurance Committee. Staff will also notify Administration.
  - 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 Quality Assurance Committee per organizational policy.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 8 OF: 10
	EFFECTIVE:
APPROVED BY: Board of Managers	REVISED: 2/2010km

- 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.

**All medication errors and adverse drug reactions will also be reported to the consulting Pharmacist.**

- Established organizational policy (such as the Sentinel Event Policy) and/or the Quality Assurance 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 Quality Assurance 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 #6016
	PAGE: 9
	OF: 10
	EFFECTIVE:
APPROVED BY: Board of Managers	REVISED: 2/2010km

- 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. 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 Quality Assurance 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 Quality Assurance Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Quality Assurance 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 Human Resources Department and/or his or her department supervisor.
  - As part of this organization's culture of safety, 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.
  - On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #6016
	PAGE: 10 OF: 10
	EFFECTIVE:
APPROVED BY: Board of Managers	REVISED: 2/2010km

- 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.
- 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 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 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.
- Patient safety reports from the Quality Assurance Committee will be submitted to the Board of Managers.



## SEDATION DENTAL CENTER

### Our Annual Review of Care Plans and Quality Indicators Date \_\_\_\_\_ Period 2015-2016 PSC Review

Goals we collect data, aggregate and analyze:

**We set priorities for our performance improvement activities (QAPI);** we focus on high risk, high volume, and problem-prone areas. Items we consider, when selecting the measures/indicators that will shape our improvement activities in these areas.

The following: incidence (rate or frequency), prevalence (how widespread something is in an ASC at a given point in time), severity (any single instance of a transfer, serious adverse event are items we consider.

Outcomes Indicators measure results of care; typical outcomes measures include risk-adjusted mortality rates, complication rates, healthcare-associated infection rates, length of stay, readmission rates, etc. In the ASC setting, outcomes measures might focus on things like complication rates, healthcare-associated infection rates, cases exceeding 24 hours, transfers to hospitals, wrong site surgeries, etc.

Process of Care Indicators measure how often the standard of care was met for patients with a diagnosis related to that standard. For example, we measure on the administration and time of prophylactic antibiotics.

Patient Perception Indicators measure a patient's experience of the care he/she received in the ASC.

We model our surveillance on the National Quality Forum's (NQF) consensus standards for ASCs, and we use only illustration of several types of measures we chose to include in our QAPI program below:

- Patient Burn – Percentage of ASC admissions experiencing a burn prior to discharge
- Prophylactic Intravenous Antibiotic Timing – Percentage of ASC patients who received appropriate antibiotics ordered for surgical site infection prophylaxis on time
- Hospital Transfer/Admission – Percentage of ASC admissions requiring a hospital transfer or hospital admission prior to being discharged from the ASC
- Patient Fall – Percentage of ASC admissions experiencing a fall in the ASC
- Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, and Wrong Implant - Percentage of ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant.

<b>Plans</b>  <b>Process Indicators</b>  <b>Outcome or Event Indicators</b>  <b>Goals</b>	<b># of Variances</b> (track adverse patient events and patient care issues)	<b>Performance Improvement and Compliance Activities or Policy Changes</b>	<b>QI Audits Completed</b>	<b>Goals Met</b> (Goals Indicated on Audits)	<b>Scope Met</b>	<b>Performance Met</b>	<b>Effectiveness</b> 1. Effective 2. Partially 3. Not Effective	<b>Review and update Policy and procedures (audits) annually or as needed</b>  <b>Comments or Items to mitigate</b>
<b>Safety</b>  Falls (Goal 0)  Patient or Employees falls (Goal 0)	1 Employee needle stick  None  None	<ul style="list-style-type: none"> <li>- Emp. Sent for TX</li> <li>- Monthly Hazard Surveillance Audit</li> <li>- Eyewash Log revised staff in serviced</li> </ul>	Daily	YES    YES	YES    YES	YES    YES	Effective	Proactive Risk Analysis (FMEA) Falls, fall assessment/incident form,
<b>Radiological Safety</b>  Unacceptable Dosimeter readings (Goal 0)  Improper use of PPE (Goal 0)	None  None	Dosimeter badges monitored quarterly- new badges ordered for new machine testing	Daily (Radiology) quarterly PPE/hand washing audits	YES  YES	YES  YES	YES  YES	Effective	Annual State monitoring and checking equipment.  Documentation In QI Binder if reading is too high  Document infection control binder
<b>Security (Goal 0)</b>	None	Doors Locked	Daily	YES	YES	YES		No firearms allowed at SDC sign on front door

<b>Hazardous Materials</b>	None	Large biohazard container	Daily	YES	YES	YES	Partially	Continue to audit for compliance
Destruction Notice checked	None							
Spills (Goal 0)	None	Spill kit in storage	12					
<b>Waste Management</b>	None	None	12	YES	YES	YES	Effective	
Pick-up timely								
<b>Emergency Management</b>	None	Drills done: Code Blue, MH Drill, Evacuation Drill, Earthquake Drill	12	YES	YES	YES	Partially	All drills conducted quarterly
<b>Internal /External</b>								
100% compliance								
<b>Fire Safety</b>		Extinguishers Q/mo	12	YES	YES	YES	Effective	100% compliance
Burns Patient or staff (Goal 0)	None	Fire Drill conducted	1					100% compliance
Quarterly Fire Drills conducted		Extinguisher training	4					100% compliance
<b>Medical Equipment</b>		All equipment either repaired or replaced.	12	YES	YES	YES	Effective	None
Equipment problems identified	None	All equipment checked prior to use	12					All equipment checked prior to use.
Injuries patient or staff (Goal 0)	None							
<b>Utility Management</b>	None	Utility Failure Response Plan	Yes	YES	YES	YES	Effective	Executed
<b>Medical Gases</b> (100% compliance)	None	None	Q DOS	YES	YES	YES	Effective	Tanks Checked
<b>Human Resources</b>	None	Revised employee file checklist	12	YES	YES	YES	Effective	Revised employee file checklist
		Evals completed						Evals. completed
		Competencies current						Competencies current

<b>Infection Control</b>  Surgical Infections (Goal 0)  Facility Acquired Infections (Goal 0)	None  None	Monthly Adverse Complication reports  Infectious risk analysis Completed  Quarterly surveillance for Aseptic technique, hand hygiene and safe needle practices, disinfecting surfaces. Sterilization logs	12	YES	YES	YES	Effective	No infections reported  Updated Risks  CMS audits completed
<b>Leadership</b> (100% compliance)  Morning Rounds  Credentialing	None  None	Contract review  Daily checks  HIPAA, Application, competencies ...etc	Annually Monthly	YES  YES	YES  YES	YES  YES	Effective  Effective	None  None
<b>Life Safety Code</b> (100% Compliance)	None	Audits per schedule	12	YES	YES	YES	Effective	None
<b>Medication Mgmt</b> Med. Errors (Goal 0)  Adverse reactions (Goal 0)  Near Misses (Goal 0)	Used single dose vial as a multi-dose  None  None	No adverse reaction to patient, no patient harm, no incorrect dosage	DOS	YES	YES	YES	Effective	Meeting on event, disciplinary action, followed up with patients. Medication logs checked daily. No missing medications noted. Medications are recorded in their own binder. Medications are signed off with two Licensed Personnel

<b>National Patient Safety Goals</b>			NA	YES	YES	YES	Effective	Alternate site marking policy
Medication Labels (100% Compliant)	None							Joint Commission revisions
Patient Identification (100% compliant)	None							Staff in-serviced
Universal Protocol (100% compliant)	None							Safety Checklist Implemented
<b>Record of Care</b> (100% compliant)	None	Monthly Audits Completed	12	YES	YES	YES	Effective	None
<b>Patient Rights</b>								
Grievances (Goal 0)	None	New process for patient notification	NA	YES	YES	YES	Effective	New process for patient notification
Complaints (Goal 0)	None							
<b>Transplant</b>	None		NA	YES	YES	YES	Effective	None
<b>Waived Testing</b> 100% compliant	None		1	YES	YES	YES	Effective	New Controls ordered
								Disinfection Policy staff in-service
								Competencies current
<b>Policy &amp; Procedure Manual</b>	None	Update manual to changes for CMS and Accreditation agency	NA	YES	YES	YES	Effective	Revised polices to Chapters 2,4,5,6,7,9,10
								Staff in-serviced to changes
<b>Hazard Vulnerability Analysis</b>	None		monthly				Effective	Updated no changes necessary

<b>Patient Care/Provision of Care</b>	None	Respect to all patients. Prompt assistance. Being courteous to patients and family	Call back-ask about these topics	YES	YES	YES	Effective. Received some complaints about surgery wait time	
<b>Environment of Care</b>	None	Safety and Security. Performing Maintenance. MSDS binder. Spill Kit. Oxygen tanks stored correctly. Fire Drill/Mock Code/Earthquake drills performed quarterly. Monitors with updated Biomed stickers.		YES	YES	YES		Biomed list of equipment checked. Fire Drills conducted quarterly. Crash cart checklists done monthly and pharmacist checks. Training with MSDS completed
<b>Emergency Management</b>	None	Training quarterly. Generator Maintenance log, Battery Check		YES	YES	YES		

# Sahara Surgery Center

## 2016 Patient Safety Program

*Our Mission is focused on delivering the highest quality healthcare that effectively responds to the needs and safety of our patients by minimizing the possibility for injury or harm to our patients. Sahara Surgery Center has developed a Patient Safety Program to maintain an effective ongoing facility-wide, data driven process to prevent and reduce medical errors and adverse events.*

### Components of Patient Safety Plan

- **Significant Event/Significant Medical Error** - Any unexpected occurrence involving a death, serious physical or psychological injury or risk thereof. Serious injury specifically includes loss of limb or function. "Risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome.
- **Adverse Events**—any event where result is not consistent with the desired plan of care and that leads to patient harm not limited to medication error.
- **Reportable Events**—Mandatory Reporting of Sentinel Events to the Nevada Sentinel Events Registry. To Nevada State Health Division, Bureau of Health Planning and Statistics. **Attention: Sentinel Events Registry, 4150 Technology Way, Suite 104, Carson City, NV 89706**

### HISTORY

Nevada Assembly Bill 1 (AB1) was passed during the 2002 18<sup>th</sup> Special Legislative Session, and mandatory reporting of sentinel events was incorporated into Nevada Revised Statute (NRS) 439.800-890 and Nevada Administrative Code (NAC) 439.900-920. Assembly Bill 59 (AB59) was passed during the 2005 73<sup>rd</sup> Session of the Nevada Legislature, and codified "facility acquired infection" as a reportable sentinel event.

A "sentinel event" is defined 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 (NRS 439.830) It is called a sentinel event because it signals the need for immediate investigation and response.

### PATIENT SAFETY OFFICER

- Designated employee of the facility
- Serve on the Patient Safety Committee
- Supervises the reporting of all sentinel events alleged to have occurred at the Facility
- Follows the Mandatory Reporting requirements according to the State of Nevada NRS 439.835

- Takes actions to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the Facility.
- Reports to the Patient Safety Committee regarding any action taken.

#### **PATIENT SAFETY COMMITTEE**

- Membership: at least three providers of health care who treat patients at the Facility, including without limitation, at least one member of the medical, nursing and pharmaceutical staff of the Facility
  - One member of the executive or governing body of the Facility
- Shall meet at least once a month
- Receives and reviews reports from the Patient Safety Officer
- Reviews and evaluates the quality measures carried out by the Facility to improve the safety of patients who receive treatment at the Facility.
- Makes recommendations to the Governing Body to reduce the number and severity of sentinel events that occur at the Facility.
  - Quarterly report to the Governing Body to include:
    - The number of sentinel events that occurred at the Facility during the preceding calendar quarter; and
    - Any recommendations to reduce the number and severity of sentinel events that occur at the Facility

#### **Process for Reporting**

1. A designated Patient Safety Officer will be assigned by the facility and register with the Sentinel Events Registry as the facility's reporting contact.
2. Complete the Nevada State Health Division Sentinel Event Report – Amendment by fax to 775-684-4156 or send Certified Mail with a return receipt to: the Nevada State Health Division, Bureau of Health Planning and Statistics Att. Sentinel Events Registry, 4150 Technology Way, Suite 104, Carson City, NV 89706

#### **Medical Errors**

1. See policy for Patient Notification of Medical Error in Administration Policy and Procedure Manual.
2. Steps in the Patient Notification of Medical Error are followed
  - a. A Variance form is completed
  - b. A Root Cause Analysis (RCA) is performed
  - c. The patient's Medical Record is sent for Peer Review
  - d. The Medical Record and peer review findings go before MEC/GB for action and/or recommendations along with the RCA Plan of action and risk reductions strategies.

#### **Adverse Events and Reportable Events**

- A variance report is completed.
- Variance is submitted to QI/Risk Manager
- Variance is reported on Service Quality Index
- If significant event: a Root Cause Analysis is performed
- Clinical Director of Quality and Risk Management for the Far West is notified
- If applicable, a Probable Claim Report (PCR) is filed.
- Patient Medical Record is sent for peer review
- The Medical record, RCA and peer review results goes to MEC/GB for actions and/or recommendations.



### **Time Frames for Internal reporting of Medical Errors, Adverse Events and Reportable Events**

- The person most closely involved or the person discovering the variance should prepare the variance and report to the Risk Manager or designated person as soon as possible following the event.
- Reportable events will be reported by making mandatory reports to regulatory agencies as required by laws and regulations following reporting deadlines (CMS, FDA, SMDA, local law enforcement).

### **Consequences for failing to report events in accordance with policy**

- Employee failure to report a reportable event may result in disciplinary action.

### **Mechanisms for preservation and collection of event data**

1. Notify:
  - QI/Risk Manager/Safety Officer
  - Administrator
  - Medical Director
  - Clinical Manager
  - QI Committee
  - HCI
  - Regional Director of Quality and Risk Management
2. If the event is a result of faulty equipment or product, equipment/product will be retained along with packaging.
3. Variance report will be completed along with Mandatory Safe Medical Device Form 3500A if applicable.
4. Investigation is initiated.
  - a. Involved staff is interviewed
  - b. Copy of patient medical record if applicable
  - c. Copy of any medical treatment rendered outside of surgery center
  - d. Decision by the QI Committee/Quality and Risk Manager as to whether or not incident is reportable.
  - e. File a Probable Claim Report (PCR) with HCI if recommended by QI Committee/Quality and Risk Manager
  - f. Complete FDA forms if incident is reportable and if applicable
  - g. If appropriate, notify manufacturer

### **Process for conducting a Root Cause Analysis (RCA)**

1. A committee involving representatives from each area including business office.
2. Have available the Policy and Procedure manual, Risk and QI Manuals, Medical staff Bylaws and rules and regulations, CMS regulatory statutes and state regulatory statutes, incident medical record, variance report, and peer review report and lastly the measurement tool to be used.
3. Review of variance report by the group
4. Review RCA form with the group
5. Staff directly involved with event will describe their interaction with the patient and the policy and procedures that support their work.
6. Identify "WHY" each contributing factor occurred or did not occur when it should have.
7. Develop a risk reduction strategy for each root cause

8. Develop a measurement strategy to evaluate effectiveness of reduction
9. All questions will be addressed
10. All investigations and rationale are documented
11. Explanations are summarized and are submitted as attachments to the MEC/GB
12. Administrator/MEC/GB will communicate actions and recommendations to Risk Manager
13. Risk Manager will hold a meeting with QI committee
14. A meeting with affected departments is held to communicate risk reduction strategies and measurement of outcome.

**Patient Safety training will be provided to designated staff on an annual basis**

- Training will include all Components listed above.

**Sahara Surgery Center will designate one or more individuals to be responsible for the management of the Patient Safety Program. Responsibilities shall include**

- Coordinating all patient safety activities/in-services
- Monthly rounds of the facility utilizing an individualized checklist for the center for compliance to policies and potential areas of risk. This checklist is printed from the Risk Manager's Workbook and returned to the Risk Manager for immediate remedy for non-compliance as well as tracking and trending of deficiencies,
- Facilitating assessment and appropriate response to reported events
- Monitoring the RCA and results in recommendations and action plans
- Serve as liaison among the Centers' departments and committees to ensure facility-wide integration of Patient Safety Program with Risk Management and report finding quarterly to the Quality Improvement Committee.

**The designated person will have completed the process for the reportable event within 45 days**

- A Root Cause Analysis will be completed to examine the cause and effect of the event through an impartial process
- An action plan will be developed identifying strategies that the Center intends to employ to reduce the risk of similar events occurring in the future.
  - Action plan designates responsibility for implementation and oversight.
  - Time frames for implementation will be specified
  - Strategy for measuring effectiveness will be included
- The RCA and action plan will be available for review by department representatives

**Reporting Requirements**

Any theft of drugs and/or diversion of controlled drugs shall be reported to the local police agency, the State Board of Pharmacy, the Nevada Department of Public Safety and/or the Drug Enforcement Administration.

**Best Practices Report**

All Best practice initiatives will be reviewed and the Meaningful Difference implemented after review by the Quality Committee and approved by the Governing Body.

## **Assembly Bill 280 (AB280)**

Requires the adoption of patient safety checklists and patient safety policies to be monitored and reviewed annually by the patient safety committee at the medical facility. AB280 requires annual reporting by the medical facility to the Director of the Legislative Counsel Bureau.

### **HISTORY**

Assembly Bill AB 280 went into effect on July 1, 2011. AB 280 was incorporated into NRS 439.865, 439.875 and requires the adoption of patient safety checklists and patient safety policies at certain medical facilities.

### **Patient safety checklists must follow protocols to improve the health outcomes of patients and include the following**

- Documentation that the treatment provided was properly ordered by the provider of health care.
- Protocols to ensure that the room and environment of the patient is sanitary.
- Checklist when discharging a patient to verify the patient has received:
  - Proper instructions concerning prescription medications
  - Instructions concerning aftercare
  - Any other instructions concerning his or her discharge.
- Any other checklist to ensure the safety of the patients at the facility.

### **Patient safety policies to include**

- Policy for appropriately identifying a patient before treatment. Policy must require the patient to be identified with at least two identifiers before each interaction with a provider of health care. Personal identifiers may include:
  - Patient name
  - Patient date of birth
- Policy regarding the nationally recognized standard precautionary protocols to be observed by health care providers, including protocols relating to hand hygiene.
- Policy to ensure compliance with the patient safety checklists and patient safety policies.

### **Patient safety committee shall**

- Monitor and document the effectiveness of the patient identification policy.
- At least annually, review the patient safety checklists and patient safety policies.
- Revise the patient safety checklists and safety policies to ensure the checklists or policies reflect the most current standards in patient safety protocols.

### **Reporting**

- On or before July 1 of each year, the medical facility will submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care.

# **RENO ORTHOPAEDIC SURGERY CENTER, LLC**

---

## **NURSING MANUAL**

### **SECTION V - SAFETY**

*APPROVED BY: BOARD OF DIRECTORS*

---

*SUBJECT: SAFETY PROGRAM*

*EFFECTIVE DATE: OCTOBER 12, 2007*

*REVISED: FEBRUARY 28, 2012*

---

**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. The Clinical Manager will appoint a Safety Officer.
3. The Safety Committee will meet monthly.
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**

---

## **NURSING MANUAL**

### **SECTION V - SAFETY**

*APPROVED BY: BOARD OF DIRECTORS*

---

#### 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.

**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 1/2016

**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 Control in Reprocessing of Flexible Gastrointestinal Endoscopes 2015
- c. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Guideline for Use of High Level Disinfectants and Sterilants for Reprocessing Flexible Gastrointestinal Endoscopes 2013
- d. American Society for Gastrointestinal Endoscopy (ASGE) Infection Control during GI Endoscopy 2008
- e. Center for Disease Control (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007
- f. CDC Guide to Infection Prevention for Outpatient Settings 2014
- g. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the Elimination of Clostridium difficile in Healthcare Settings 2013
- h. 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
- f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

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.

*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.*

- 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 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.

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.

*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.*

- 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.

*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.*



## RED ROCK SURGERY CENTER

### **SUBJECT: RISK MANAGEMENT AND PATIENT SAFETY POLICY STATEMENT**

To assure the continuing ability to provide quality health care, the Center has established a risk management and patient safety program to minimize the adverse events. The risk management and patient safety program includes several activities geared toward the protection of the patient and the Center's assets and reputation.

An effective risk management and patient safety program is the responsibility of all employees and medical staff members of the Center. Periodically, the Governing Board will affirm support of and review the results of the risk management and patient safety program.

It is the intent of the Center to reduce, eliminate, and prevent conditions and practices that may cause loss. The safety and well-being of the patients, personnel, and public shall have the highest priority.

1. Risk management and patient safety activities include:
  - a. The investigation and analysis of the frequency and causes of general categories and specific types of adverse and unanticipated events causing actual or potential injury to patients, employees, physicians, and visitors.
  - b. The development of appropriate measures to minimize the risk of injuries and adverse events to patients, employees, physicians, and visitors through cooperative efforts of all personnel. These measures will include risk management, patient safety, and risk prevention education and training of all non-physician personnel as follows:
    - i. Education and training of all non-physician personnel as part of their initial orientation; and
    - ii. At least one (1) hour of such education and training annually for all non-physician personnel of the facility.
  - c. The analysis of patient grievances that relate to patient care and the quality of medical services.
  - d. The development and implementation of a reporting system based upon the affirmative duty of all health care providers and all agents and employees of the health care facility to report injuries and adverse outcomes and unanticipated events.

**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.

**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: RISK MANAGEMENT AND PATIENT SAFETY PROCESS**

The corporate liability theory is held on the belief that the Center and its Governing Board owe a duty to the patients served. The duty is established by virtue of the Center's "custody" of the patient.

The delegation by the Governing Board to the Medical Staff for peer review and credentialing activities does not absolve the Governing Board from liability. The corporate issue is that of oversight.

A redefinition of the Center's legal duty to patients has given rise to Center corporate liability for malpractice. This liability is not derived from medical negligence by physicians, but rests on a separate, independent duty to protect patients from harm.

The principal control mechanism available to the Center is an effective internal risk management and patient safety program. To implement this program effectively, it is important that the goals of risk management and patient safety are understood.

By definition, risk management and patient safety is a pro-active process instituted in an effort to protect and preserve the financial assets and reputation of the health care provider and the Center.

1. There are four basic components of risk management and patient safety.
  - a. Identification
  - b. Analysis
  - c. Treatment
  - d. Evaluation
2. Risk or exposure identification requires a systematic means of detecting potential problems and a reliable method to predict events in the future.
3. General analysis objectives are to determine where to direct attention and resources. Specific objectives for analysis are
  - a. the probable frequency of the loss
  - b. the probable cause of the loss
  - c. the possible severity of the loss
  - d. the effect that any potential loss would have on the patient and the organization.

4. Treatment includes two techniques.
  - a. Control
  - b. Risk Financing involves methods used to pay for losses
5. Evaluation includes a constant review and evaluation of the entire system to ensure its effectiveness and its compliance with all applicable statutes and external requirements.

## **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 recommended for approval by the Clinical Review Committee on 3/8/2011. It was approved by the Management Committee on 3/29/2011.

## **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: 12/01/2015

### **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 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 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 is responsible for the oversight of the Patient Safety Program. The EOC/Patient Safety Committee Chairperson will have administrative responsibility for the program, or the EOC/Patient Safety Committee may assign this responsibility to another member of the committee.

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, who will aggregate occurrence information and present a report to the EOC/Patient Safety Committee 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 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 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 and Administrator, 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.

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 and Administrator 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, describe the facts of the near miss on an occurrence report and submit the report to the Administrator.
9. At the direction of the Administrator 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 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 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 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 will be submitted to the Quality Council, Care Oversight Committee of the Medical Staff and Board QI Committee, which exists as the oversight committee for the Environment of Care/Patient Safety Committee.

## PHYSICIANS' SURGERY CENTER OF NEVADA

### **POLICY:**

Physicians' Surgery Center of Nevada has established consistent guidelines for reporting incidents possibly occurring in the Center and has specified how staff will report these incidents. An Incident report is a document, usually confidential (protected from discovery by a plaintiff in a lawsuit), describing any accident or deviation from policies or orders.

### **PROCEDURE:**

#### **Adverse or Untoward Incident**

1. Incident report is a factual written statement about a particular incident detailing particulars as to time, location, all persons directly involved including functional titles, and the nature of event including description of injuries. The report shall contain a listing of witnesses to the event.
2. "Adverse or Untoward Incident" for purposes of reporting means an event over which healthcare personnel could exercise control and is associated in whole or in part with medical intervention occurred, and
  - A. Is not consistent with or expected to be a consequence of such medical intervention; or
  - B. Occurs as a result of medical intervention to which the patient has not given his informed consent;
  - C. Occurs as the result of any other action or lack thereof on the part of the facility or personnel of the facility;
  - D. Results in a surgical procedure being performed on the wrong patient;
  - E. Results in a surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient including the surgical repair of injuries or damage resulting from the planned surgical procedure,
  - F. wrong site or wrong procedure surgeries, and procedures to remove foreign objects remaining from surgical procedures;
  - G. Causes injury to a patient as defined "Injury" for the purposes of reporting to the Agency is any of the following outcomes when caused by an adverse incident:
    - i. Death;
    - ii. Brain damage;
    - iii. Spinal damage;
    - iv. Permanent disfigurement;
    - v. Fracture or dislocation of bones or joints;
    - vi. any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition;
    - vii. Any condition requiring surgical intervention to correct or control;
    - viii. Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care;
    - ix. Any condition that extends the patient's length of stay
    - x. Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility.
3. The procedure shall be in writing and disseminated to all employees of the

facility. All new employees, within 30 days of employment, shall be instructed about the operation of the system and responsibilities of it. At least annually all nonphysician personnel of the facility working in clinical areas and providing patient care shall receive training including the importance of accurate and timely incident reporting.

4. The incident reporting system shall include the prompt, within 3 calendar days, reporting of incidents to the risk manager. Reports shall be on a form developed by the facility for the purpose and shall contain at least the following information:
  - A. The patient's name, locating information, admission diagnosis, admission date, age and sex;
  - B. A clear and concise description of the incident including time, date, exact location; and elements as needed for the annual report based on ICD-10-CM;
  - C. Whether or not a physician was called; and if so, a brief statement of said physician's recommendations as to medical treatment, if any;
  - D. A listing of all persons then known to be involved directly in the incident, including witnesses, along with locating information for each;
  - E. The name, signature and position of the person completing the reports, along with date and time that the report was completed.
5. Staff will document all incidents described in this policy on the Incident Reporting Form, which is provided as a supplement to this policy. Staff will use this form regardless of the incident. This form and policy cover all incidents occurring in the facility or on the facility grounds. The Clinical Director/Risk Manager will maintain these records in the facility.
6. A staff member shall complete the form within 24 hours of the incident.
7. The reporting staff person will complete the form, leaving NO BLANKS.
8. Reporting staff will fill in the form legibly.
9. The patient's medical records shall reflect the incident, but not the incident report completion.
10. If the incident involves a medical device, which does not work properly, write down the make, model, and serial number, and remove the equipment. Label the equipment, "Broken Do Not Use."
11. The incident report should NEVER be copied and should always be kept in a secure location:
12. The Risk Manager shall be responsible for the regular and systematic reviewing of all incident reports, for the purpose of identifying trends or patterns as to time, place or persons: and upon emergence of any trend or pattern in incident occurrence shall develop recommendations for corrective actions and risk management prevention education and training. Summary data thus accumulated shall be systematically maintained for three years.
  - A. At least quarterly or more often as may be required by the governing body, the risk manager shall provide a summary report to the governing body which includes information about activities of risk management as defined herein.

#### **Sentinel Event Reports:**

1. An unexpected occurrence involving death or serious physical injury or the risk thereof is a sentinel event. A sentinel event includes, but is not limited to:
  - A. Procedure on the wrong person or wrong body part.
  - B. Fractures of major limbs or joints.
  - C. Major function loss associated with procedure or medication error.
  - D. Severe burns.
  - E. Lacerations.
  - F. Hematomas.
  - G. Actual or suspected abuse or mistreatment of patients.
  - H. Rape.
  - I. Death within 30 days of a procedure at the ASC.
2. An appropriate staff member should notify the Medical Director, Risk Manager and Center Administrator immediately of any sentinel event/accident and/or medical conditions as defined above.
3. Center officials along with assistance of the Risk Manager shall report any sentinel event/accident and/or medical condition to the Nevada Department of Health and the Joint Commission, in writing, within five (5) days of the occurrence.

### **Medication Error Reports**

1. Significant medication errors and significant adverse medication reactions are those which:
  - A. Require discontinuing or modifying the dose of the prescribed medication due to unintended, undesired, and unexpected effects.
  - B. Require hospitalization.
  - C. Result in disability.
  - D. Require treatment with a prescription medication.
  - E. Result in cognitive deterioration or impairment.
  - F. Are life-threatening.
  - G. Result in death.
  - H. Incorrect dosage or medication type 'near misses'
2. Any significant medication errors and significant adverse reactions which require intervention must be reported immediately to:
  - A. The patient, parent, or next of kin.
  - B. Responsible party and
  - C. Prescriber (Admitting physician) and

- D. Supervising staff member and
- E. Clinical Director, Medical Director, and Consultant Pharmacist.

**Theft or Loss of Controlled Substances:**

1. Any theft, suspected theft, or loss of controlled substances shall be immediately reported to the:
  - A. Consultant Pharmacist
  - B. Medical Director
  - C. Clinical Director
  - D. Local law enforcement
  - E. Nevada Board of Pharmacy

Note: The loss/theft must be reported within 48 hours of its discovery.

**Fires/Disasters:**

Any fire/disaster in the facility will be immediately reported to the Division of Health Licensing. The Clinical Director will conclude reporting as directed by these agencies.

**Variations:**

Appropriate staff personnel will document investigate and report to the Quality Management Committee any process variation for which a recurrence carries a significant chance of a serious adverse outcome.

**Breeches:**

Appropriate staff personnel will document, investigate, and report to the Quality Management Committee any events in medical care, administrative procedure, or other breeches which could negatively affect patients.

**Reporting Quality Management**

1. Every Incident will be reviewed by the Quality Management Committee for:
  - A. Analysis of basic or causal factors, which affected the variation in performance.
  - B. Improvements in the process leading to the adverse incident, which will decrease the likelihood of similar incidents in the future.
  - C. An Action Plan, when applicable.

PARKWAY SURGERY CENTER AT  
HORIZON RIDGE

Environment of Care

**PARKWAY SURGERY CENTER**

---

**Effective Date: 02/18/09**

**Reviewed Date: 02/18/11, 02/18/12, 02/18/13, 02/18/14, 02/18/15**

**Review/Revision Date: 02/18/16**

**Policy Number: EC 000304 (Reviews Annually)**

**Policy: Life Safety Policy**

---

**PURPOSE:**

To establish a life safety management plan that will provide a fire-safe environment of care.

**SCOPE:**

All personnel.

**Life safety program elements:**

• Protection of employees, patients, and visitors

Employees shall follow the general instruction for their departments and know the evacuation routes. All facilities are equipped throughout with general purpose portable fire extinguishers. It is each employee's responsibility to know the location of these extinguishers.

• Maintaining compliance with Life Safety Code®, NFPA 2000

All buildings where patients are treated and that are under the ownership or control of the center shall maintain compliance with the appropriate provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association and county and state fire marshals.

• Inspection, testing, and maintenance of fire detection, alarm, and protection equipment

- There will be quarterly testing of all circuits, smoke dampers, and communication devices, which transmit a signal to the fire alarm company
- There will be annual preventive maintenance of all components
- All automatic fire-extinguishing systems (all components of the automatic sprinkler systems) shall be inspected and tested annually
- All portable fire extinguishers shall be clearly identified, inspected, and maintained monthly and annually
- Inspection, testing, and maintenance of the fire alarm and fire suppression systems will be performed by a qualified (state-licensed) individual who will make recommendations based on findings to the person responsible for maintaining the facility fire alarm and fire suppression systems. An

exception to this is made with the inspection of facility-owned fire extinguishers and exit lights. These devices will be inspected monthly by the safety officer and annually by a state-licensed individual. Each extinguisher is placed as appropriate, based upon the recommendation of the local fire authority.

- **Review of purchases**

All purchases of furnishings and equipment shall be reviewed to determine whether they meet fire retardant characteristics and flame spread resistance necessary for continued fire safety. All acquired supplies, furnishings, and equipment will have approval by the Food and Drug Administration prior to use.

- **Reporting and investigation of life safety deficiencies**

A comprehensive plan to correct any life safety deficiencies that occur or are identified by any source shall be developed immediately in writing and shall address

- all Life Safety Code deficiencies
- notification of the chief quality officer/safety officer
- corrective actions (plan for improvement)
- total cost of actions and specific funding information
- reasonable schedule for completion
- coordination with available funding
- all interim life safety measures that have been implemented and are currently enforced

- **Orientation to and education in the life safety program**

All employees know their roles and responsibilities both at the point of origin of a fire and away from the point of origin, use and functioning of fire alarm systems, and how to contain smoke/fire with building compartmentalization. In addition to the initial orientation, all employees shall receive annual retraining on life safety.

- **Emergency procedures**

All emergency procedures for fire response are found in this manual.

- **Annual evaluation**

The life safety program shall be evaluated annually for its effectiveness.

- **Performance improvement standards**

The safety committee will meet monthly or when necessary to review life safety activities. Summaries of findings shall be forwarded to the performance review committee.

- **Performance indicators**

The following indicators shall be utilized in the evaluation of life safety performance\*:

Number of fire drills conducted (quarterly, with 50% unannounced)

- Evaluation of quarterly drills

- Whether employees can describe evacuation procedures

- Whether fire alarm and fire detection system tests are completed according to the preventive maintenance criteria

- Fire extinguisher maintenance inspections completed (monthly and annually)

- Fire-extinguishing system inspections completed (annually)



## PARKWAY AMBULATORY SURGERY CENTER

## Environment of Care

**PARKWAY SURGERY CENTER**

---

**Effective Date: 02/18/09****Reviewed Date: 02/18/11, 02/18/12, 02/18/13, 02/18/14, 02/18/15****Review/Revision Date: 02/18/16****Policy Number: EC 000304 (Reviews Annually)****Policy: Life Safety Policy**

---

**PURPOSE:**

To establish a life safety management plan that will provide a fire-safe environment of care.

**SCOPE:**

All personnel.

**Life safety program elements:**

- Protection of employees, patients, and visitors

Employees shall follow the general instruction for their departments and know the evacuation routes. All facilities are equipped throughout with general purpose portable fire extinguishers. It is each employee's responsibility to know the location of these extinguishers.

- Maintaining compliance with Life Safety Code®, NFPA 2000

All buildings where patients are treated and that are under the ownership or control of the center shall maintain compliance with the appropriate provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association and county and state fire marshals.

- Inspection, testing, and maintenance of fire detection, alarm, and protection equipment

- There will be quarterly testing of all circuits, smoke dampers, and communication devices, which transmit a signal to the fire alarm company
- There will be annual preventive maintenance of all components
- All automatic fire-extinguishing systems (all components of the automatic sprinkler systems) shall be inspected and tested annually
- All portable fire extinguishers shall be clearly identified, inspected, and maintained monthly and annually
- Inspection, testing, and maintenance of the fire alarm and fire suppression systems will be performed by a qualified (state-licensed) individual who will make recommendations based on findings to the person responsible for maintaining the facility fire alarm and fire suppression systems. An

exception to this is made with the inspection of facility-owned fire extinguishers and exit lights. These devices will be inspected monthly by the safety officer and annually by a state-licensed individual. Each extinguisher is placed as appropriate, based upon the recommendation of the local fire authority.

- **Review of purchases**

All purchases of furnishings and equipment shall be reviewed to determine whether they meet fire retardant characteristics and flame spread resistance necessary for continued fire safety. All acquired supplies, furnishings, and equipment will have approval by the Food and Drug Administration prior to use.

- **Reporting and investigation of life safety deficiencies**

A comprehensive plan to correct any life safety deficiencies that occur or are identified by any source shall be developed immediately in writing and shall address

- all Life Safety Code deficiencies
- notification of the chief quality officer/safety officer
- corrective actions (plan for improvement)
- total cost of actions and specific funding information
- reasonable schedule for completion
- coordination with available funding
- all interim life safety measures that have been implemented and are currently enforced

- **Orientation to and education in the life safety program**

All employees know their roles and responsibilities both at the point of origin of a fire and away from the point of origin, use and functioning of fire alarm systems, and how to contain smoke/fire with building compartmentalization. In addition to the initial orientation, all employees shall receive annual retraining on life safety.

- **Emergency procedures**

All emergency procedures for fire response are found in this manual.

- **Annual evaluation**

The life safety program shall be evaluated annually for its effectiveness.

- **Performance improvement standards**

The safety committee will meet monthly or when necessary to review life safety activities. Summaries of findings shall be forwarded to the performance review committee.

- **Performance indicators**

The following indicators shall be utilized in the evaluation of life safety performance\*:

Number of fire drills conducted (quarterly, with 50% unannounced)

- Evaluation of quarterly drills
- Whether employees can describe evacuation procedures
- Whether fire alarm and fire detection system tests are completed according to the preventive maintenance criteria
- Fire extinguisher maintenance inspections completed (monthly and annually)
- Fire-extinguishing system inspections completed (annually)

## Environment of Care

### **PARKWAY SURGERY CENTER**

---

**Effective Date:** 02/18/09

**Reviewed Date:** 02/18/11, 02/18/12, 02/18/13, 02/18/14, 02/18/15

**Review/Revision Date:** 02/18/16

**Policy Number:** EC 000304 (Reviews Annually)

**Policy:** Life Safety Policy

---

#### **PURPOSE:**

To establish a life safety management plan that will provide a fire-safe environment of care.

#### **SCOPE:**

All personnel.

#### **Life safety program elements:**

- Protection of employees, patients, and visitors

Employees shall follow the general instruction for their departments and know the evacuation routes. All facilities are equipped throughout with general purpose portable fire extinguishers. It is each employee's responsibility to know the location of these extinguishers.

- Maintaining compliance with Life Safety Code®, NFPA 2000

All buildings where patients are treated and that are under the ownership or control of the center shall maintain compliance with the appropriate provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association and county and state fire marshals.

- Inspection, testing, and maintenance of fire detection, alarm, and protection equipment

- There will be quarterly testing of all circuits, smoke dampers, and communication devices, which transmit a signal to the fire alarm company
- There will be annual preventive maintenance of all components
- All automatic fire-extinguishing systems (all components of the automatic sprinkler systems) shall be inspected and tested annually
- All portable fire extinguishers shall be clearly identified, inspected, and maintained monthly and annually
- Inspection, testing, and maintenance of the fire alarm and fire suppression systems will be performed by a qualified (state-licensed) individual who will make recommendations based on findings to the person responsible for maintaining the facility fire alarm and fire suppression systems. An

exception to this is made with the inspection of facility-owned fire extinguishers and exit lights. These devices will be inspected monthly by the safety officer and annually by a state-licensed individual. Each extinguisher is placed as appropriate, based upon the recommendation of the local fire authority.

- **Review of purchases**

All purchases of furnishings and equipment shall be reviewed to determine whether they meet fire retardant characteristics and flame spread resistance necessary for continued fire safety. All acquired supplies, furnishings, and equipment will have approval by the Food and Drug Administration prior to use.

- **Reporting and investigation of life safety deficiencies**

A comprehensive plan to correct any life safety deficiencies that occur or are identified by any source shall be developed immediately in writing and shall address

- all Life Safety Code deficiencies
- notification of the chief quality officer/safety officer
- corrective actions (plan for improvement)
- total cost of actions and specific funding information
- reasonable schedule for completion
- coordination with available funding
- all interim life safety measures that have been implemented and are currently enforced

- **Orientation to and education in the life safety program**

All employees know their roles and responsibilities both at the point of origin of a fire and away from the point of origin, use and functioning of fire alarm systems, and how to contain smoke/fire with building compartmentalization. In addition to the initial orientation, all employees shall receive annual retraining on life safety.

- **Emergency procedures**

All emergency procedures for fire response are found in this manual.

- **Annual evaluation**

The life safety program shall be evaluated annually for its effectiveness.

- **Performance improvement standards**

The safety committee will meet monthly or when necessary to review life safety activities. Summaries of findings shall be forwarded to the performance review committee.

- **Performance indicators**

The following indicators shall be utilized in the evaluation of life safety performance\*:

Number of fire drills conducted (quarterly, with 50% unannounced)

- Evaluation of quarterly drills
- Whether employees can describe evacuation procedures
- Whether fire alarm and fire detection system tests are completed according to the preventive maintenance criteria
- Fire extinguisher maintenance inspections completed (monthly and annually)
- Fire-extinguishing system inspections completed (annually)

## Environment of Care

### PARKWAY SURGERY CENTER

---

**Effective Date:** 02/18/09

**Reviewed Date:** 02/18/11, 02/18/12, 02/18/13, 02/18/14, 02/18/15

**Review/Revision Date:** 02/18/16

**Policy Number:** EC 000304 (Reviews Annually)

**Policy:** Life Safety Policy

---

#### **PURPOSE:**

To establish a life safety management plan that will provide a fire-safe environment of care.

#### **SCOPE:**

All personnel.

#### **Life safety program elements:**

- Protection of employees, patients, and visitors

Employees shall follow the general instruction for their departments and know the evacuation routes. All facilities are equipped throughout with general purpose portable fire extinguishers. It is each employee's responsibility to know the location of these extinguishers.

- Maintaining compliance with Life Safety Code®, NFPA 2000

All buildings where patients are treated and that are under the ownership or control of the center shall maintain compliance with the appropriate provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association and county and state fire marshals.

- Inspection, testing, and maintenance of fire detection, alarm, and protection equipment

- There will be quarterly testing of all circuits, smoke dampers, and communication devices, which transmit a signal to the fire alarm company
- There will be annual preventive maintenance of all components
- All automatic fire-extinguishing systems (all components of the automatic sprinkler systems) shall be inspected and tested annually
- All portable fire extinguishers shall be clearly identified, inspected, and maintained monthly and annually
- Inspection, testing, and maintenance of the fire alarm and fire suppression systems will be performed by a qualified (state-licensed) individual who will make recommendations based on findings to the person responsible for maintaining the facility fire alarm and fire suppression systems. An

exception to this is made with the inspection of facility-owned fire extinguishers and exit lights. These devices will be inspected monthly by the safety officer and annually by a state-licensed individual. Each extinguisher is placed as appropriate, based upon the recommendation of the local fire authority.

- **Review of purchases**

All purchases of furnishings and equipment shall be reviewed to determine whether they meet fire retardant characteristics and flame spread resistance necessary for continued fire safety. All acquired supplies, furnishings, and equipment will have approval by the Food and Drug Administration prior to use.

- **Reporting and investigation of life safety deficiencies**

A comprehensive plan to correct any life safety deficiencies that occur or are identified by any source shall be developed immediately in writing and shall address

- all Life Safety Code deficiencies
- notification of the chief quality officer/safety officer
- corrective actions (plan for improvement)
- total cost of actions and specific funding information
- reasonable schedule for completion
- coordination with available funding
- all interim life safety measures that have been implemented and are currently enforced

- **Orientation to and education in the life safety program**

All employees know their roles and responsibilities both at the point of origin of a fire and away from the point of origin, use and functioning of fire alarm systems, and how to contain smoke/fire with building compartmentalization. In addition to the initial orientation, all employees shall receive annual retraining on life safety.

- **Emergency procedures**

All emergency procedures for fire response are found in this manual.

- **Annual evaluation**

The life safety program shall be evaluated annually for its effectiveness.

- **Performance improvement standards**

The safety committee will meet monthly or when necessary to review life safety activities. Summaries of findings shall be forwarded to the performance review committee.



- **Performance indicators**

The following indicators shall be utilized in the evaluation of life safety performance\*:

Number of fire drills conducted (quarterly, with 50% unannounced)

- Evaluation of quarterly drills

- Whether employees can describe evacuation procedures

- Whether fire alarm and fire detection system tests are completed according to the preventive maintenance criteria

- Fire extinguisher maintenance inspections completed (monthly and annually)

- Fire-extinguishing system inspections completed (annually)

The Sentinel Event Summary Report and Sentinel Event Contact From have been removed based on NRS439.843.

## CHAPTER 7

### Infection Prevention and Control & Safety

# Policies & Procedures

**NRS 439.865-4.39.880**

**Policies 7 Subchapter II:**

**Safety  
Safety Checklists**

Reviewed as of 1/16/2016

**SUBJECT: SAFETY MANAGEMENT PLAN**

**POLICY NUMBER: 7.II**

**Policy:**

It is the policy of NSS that there be an active and on-going Safety Management Plan which is designed, implemented and evaluated in a planned and coordinated manner to accomplish the following goals:

1. Appointment of a qualified individual to oversee the development, implementation and monitoring of the Safety Management Plan. The Director of Nursing is responsible for overseeing this plan.
  1. Shall serve on the Safety Committee
  2. Supervise the reporting of all sentinel events alleged to have occurred at the facility
  3. Take such action he/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 the the facility
  4. Report to the safety committee regarding any action taken with paragraph (3).
2. Identification of an individual(s) to intervene whenever conditions pose an immediate threat to life, health, and/or safety. The Medical Director will fulfill this role.
3. Completion of proactive risk assessments that evaluate the potential adverse impact of buildings, grounds, equipment, occupants and internal physical systems on the safety and health of patients, staff and other people coming to our facility. Risk assessments will be completed via review and trending of all incidents of property damage, patient, visitor and employee injuries, and/or feedback from employees. Additionally checklists will be utilized for screening.
4. Patient, Visitor and Employee incidents will be reported to, and investigated by the Nurse Manager. The Risk Management Policy interfaces with the safety policy and should be referenced at the same time.
5. Incident trend summaries will be reviewed quarterly and reduction strategies identified and implemented as appropriate.
6. The safety plan will be developed in consultation with the providers of the facility. The providers will have representation in the safety committee through the medical director.
7. Assures that all grounds and equipment are maintained appropriately. A Facility Safety Checklist will be conducted monthly throughout the facility. Equipment will be managed per the Equipment and Facility Maintenance policy. These policies will reflect the manufactures instructions and guidance.

- i. The Facility Safety Checklist will be reviewed quarterly by a representative of the Quality Assurance Committee and report data to the Committee at least annually or more often as needed.
- ii. The Quality Assurance Committee will evaluate the Safety Management Plan as needed and review at least annually.
- iii. After evaluation from the QA committee the Safety plan will be submitted to the Governing Board for approval.
- iv. After Governing Board approval the facility shall notify all providers of health care who provide treatment to patients at the facility of the existence of the plan and the requirements of the plan.

Compliance with the safety plan is required of all staff.

The Safety Management Plan will address the above noted goals as they relate to patients, employees, physicians, visitors, and the community.

#### **Procedures:**

#### **Responsibilities**

##### Governing Body:

1. The NSS Governing Body requires the existence of an active and effective Safety Management Plan. This program includes on-going efforts in problem identification, resolution, monitoring, and evaluation.
2. The Quality Assurance Committee has the responsibility of overseeing and monitoring compliance with the requirements of this plan.
3. Identified safety management issues are communicated periodically to the Governing Body.
4. The Governing Body authorizes the Director of Nursing to take any actions appropriate to eliminate or minimize a threat which poses an immediate threat to life or health or poses a threat of damage to equipment or building.

##### The Medical Staff:

1. Participate in the identification of potential risks in the clinical aspects of patient care and safety.
2. Assist with the correction of associated problems and the design of programs to reduce risks.

Director of Nursing:

The Director of Nursing will assume responsibility for the overall coordination of the Safety Management Program.

The Director of Nursing will:

1. Provide and oversee orientation and continuing education programs for all employees as it relates to health and safety.
2. Ensure compliance with safety-related standards from the various regulatory agencies.
3. Prepare appropriate safety related reports, as needed.
4. Ensure that employees participate in the various safety programs/activities, both central and work area specific (e.g., orientation, continuing education, emergency preparedness drills, etc.).
5. Identify and correct hazardous conditions.
6. Correct safety hazards/potential hazards. Review safety policies and procedures, as necessary. Evaluate circumstances of work-related injuries and identify opportunities for prevention.

Employees:

All employees are responsible for supporting the Safety Management Program.

Employees will:

1. Maintain a clean, safe work environment.
2. Know and follow safety policies and procedures.
3. Report, and correct when possible, actual/potential safety hazards.
4. Report all work related injuries.
5. Attend appropriate, required educational programs.

Safety Committee:

The Safety Committee assist in establishing, supporting, and maintaining a safe and healthy environment free of hazards to employees, visitors, patients, vendors, and persons who use or visit the facility.

The Committee is responsible for providing oversight for the development, implementation, maintenance, and evaluation of the comprehensive Safety Management Plan.

NSS has less than 25 employees; therefore the Administrator will determine the composition of the safety committee (NRS 439.875 (3)).

- The safety committee will be composed of the Infection control officer, the Safety Officer, The Medical Director, Pharm consultant, RN Representative, MA representative.
- Meetings will be at least quarterly.
- The meetings will:
  - 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.
  - Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections at the medical facility.
  - Make recommendations to the governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at the medical facility.
  - At least once each calendar quarter, report to the governing body of the medical facility regarding:
    - 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.
  - 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 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](#).

**SUBJECT: SAFETY CHECKLISTS**

**POLICY NUMBER: 7.3**

**Policy:**

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. 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. On or before July 1 of each year, the Patient Safety Officer through the Administrator will 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.

**SUBJECT: PATIENT IDENTIFICATION**

**POLICY NUMBER: 7.D**

All patients will be identified prior to treatment. At least two personal identifiers before each interaction with a provider of health care must be confirmed. At NSS the personal identifiers are the name and date of birth of the patient.

**SUBJECT: EMERGENCY AND DISASTER PREPAREDNESS PLAN**

**POLICY NUMBER: 7.E**

In the event of an emergency, a member of the staff will make an announcement to the remaining uninformed staff.

The Codes are:

- Code Blue – Cardiac Arrest
- Code Red – Fire
- Code Black – Bomb Threat
- Code Yellow – External Disaster

The Emergency Preparedness Plan is designed by the Center's personnel and is specific to the Center, incorporating various aspects of an overall facility disaster plan. The Emergency Preparedness Plan includes the following:

1. Procedures included in the emergency preparedness plan:

- a. The disaster is announced.
- b. The Center shall be ready to operate at full capacity during any emergency period; all Facility personnel will be called back to duty as soon as the disaster alarm is sounded. It will be the responsibility of the Clinical Administrator or a designated person to initiate the notification system. All personnel will report to the Staff Break Room. The first RN arriving will initiate the Emergency Preparedness Plan.
- c. Call total staffing availability to the Control Center.
- d. Assess staffing needs. Report needs to the control center.
- e. Assist personnel and physicians in discharging of all non-emergency patients, to make room for disaster victims. All patients who have not received sedation will be discharged. All patients who have received sedation will be observed for 15 minutes and discharged if discharge criteria has been met and provider deems appropriate.
- f. The disaster coordinator assigns physicians to operating rooms.
- g. The coordinator consults with the control center regarding the Center's ability to accommodate victims.
- h. Patients will receive as much care as the Center is capable of providing.

2. Schedule emergency procedures in the order of event or medical priority.



3. Sample of paperwork used:

1. Log in the following information for each patient as he/she arrives:

- i. Time patient arrives;
- ii. Name of patient, if available;
- iii. Treatments performed;
- iv. Attending physician;
- v. Disaster Tag Number.

2. Roles and Responsibilities of additional personnel:

Recovery Room Nurses:

- i. Check suction, O2 tanks, monitors and defibrillators for proper functioning.
- ii. Make an inventory of supplies and obtain needed supplies.
- iii. Supervise and care for any patient awaiting treatment in the Recovery Room.

MAs:

- i. Check and restock supplies, sterile saline.
- ii. Ensure adequate supplies of linens are available.
- iii. Transport requested supplies as needed.
- iv. Help transport patients.
- v. Ensure that an adequate supply of suction canisters is available.
- vi. Clean rooms.
- vii. Remove regular and Biohazardous trash, as accumulated.

Nurses:

- i. Administer treatments to patients per physician order.
- ii. Assess emotional status of patients and offer support.
- iii. Monitor patient's status and report to physicians.

Front Desk:

- i. Answer telephones.
- ii. Assist in communication throughout the Center.
- iii. Assist with recording in logbook.

Director of Nursing:

- i. Maintain and acquire special supplies and equipment.
- ii. Assist with providing patient care.

Medical Director:

- i. Coordinate all activities.

**SUBJECT: REQUIRED TRAINING (ACLS/CPR)****POLICY NUMBER: 7.E**

All facility staff that has clinical patient contact will maintain current BLS training/certification. In addition all providers and RNs that recover patients will maintain ACLS training/certification. This ensures there are adequately trained personnel in the facility, anytime patients are present in facility.

**SUBJECT: FIRE SAFETY****POLICY NUMBER: 7.H****Purpose:**

To maintain patient, employee, and visitor safety by providing guidelines to minimize the potential for life safety and fire safety incidents.

**Guidelines:****1. Combustible Storage**

Large quantities of combustible storage should be avoided. Of special concern are loosely packed quantities of paper, cardboard, plastic, or Styrofoam which may ignite with relative ease and produce significant quantities of smoke. Additionally, fire codes require that combustible materials not be stored at heights within 18 inches of the level of drop ceiling. This would apply in particular to open storage on top of cabinets and wall mounted cupboards.

**2. Flammable Liquids**

Flammable liquids should be contained in approved flammable liquid containers, when storage levels exceed established quantity limitations as outlined in the National Fire Protection Association (NFPA) standards. The exception to this is when such containers render the liquid unsuitable for use.

**3. Electrical**

Attention should be given to the electrical integrity of equipment, evidence of potential or actual cord or plug damage, the use of "cheater" plugs and the proximity of heat producing electrical equipment to combustible materials. Three to two prong adapters are strictly prohibited. Extension cords must be sized right for the application.

**4. Barriers**

Barriers to minimize fire and/or smoke spread are important features of life safety. Fire and smoke doors should be maintained in a closed position at all times unless equipped with an automated smoke actuated

hold-open device. Door stops or wedges are unacceptable and should be limited to periods of actual need and then removed.

#### 5. Open Flames

Candles and similar items with open flames are prohibited. The presence of these items is a serious concern in regard to potential sources of fire.

#### 6. Entry or Egress

Routes of entry and egress should be maintained in an unobstructed fashion to ensure access by fire or other emergency response personnel and safe exit for occupants. Guidelines for corridor storage area:

- a. No permanent corridor storage is permitted in patient care areas.
- b. Storage in non-patient care areas should be limited to carts and materials contained in metal cabinets or files which are self-closing, attached to the wall, and fitted with a sloped top or soffit.
- c. Cabinets, files, or carts should not project beyond the face of structural pillars or obstruct EXIT or other safety-related equipment or signage.
- d. Cabinets, files, or carts should not be placed closer than 18 inches in public areas from door openings or within 36 inches of emergency equipment or pillars to which emergency equipment is attached.

#### 7. Fire Alarm and Suppression Systems

NSS is equipped with smoke detection and automatic sprinkler systems which are designed to signal, suppress, or extinguish fires in an initial stage. Alarms indicating the presence of smoke are electronically monitored.

8. The fire department is notified via annunciator panel and/or telephone. Emergency phone numbers are posted by phones in the front office/check-in area. Fire related equipment will be evaluated at least annually by contracted fire service to ensure they are functioning properly.

**SUBJECT: FIRE SAFETY MANAGEMENT PLAN**

**POLICY NUMBER: 7.H**

#### **Policy:**

It is the policy of NSS that there be an active and ongoing Fire Safety Management Plan which is designed, implemented and evaluated in a planned and coordinated manner to accomplish the following goals:

Protection of patients, employees, visitors and property from fire, smoke, and other products of combustion. This facility was designed and built using all applicable life safety guidelines/requirements applicable local and state rules and regulations.

Inspection, testing and maintenance of fire protection, fire safety systems, equipment, and components will be done on a regular basis.

Establishment of a fire safety in-services that addresses specific roles and responsibilities of employees, physicians and other licensed independent practitioners at and away from a fire's point of origin and in preparing for building evacuation, use and functioning of fire alarm systems and building compartmentalization.

Fire Drills and review of the Fire Safety Management Plan will be completed every 3 months with all facility staff. A Fire Drill Record will be completed, including:

1. Record of the staff on duty who participated,
2. Date and time of the drill, and
3. A critique of the drill.

**Fire Drills records will be maintained for 3 years.**

Evaluation of the Fire Safety Management Plan is on an annual basis. This evaluation, with goals for the coming year, will be submitted to the Governing Body for review, input, and approval.

The Fire Safety Management Plan will address the above noted goals as they relate to patients, employees, physicians, visitors, and the community.

#### Responsibilities:

The Director of Nursing is responsible for supporting the goals and objectives of the Fire Safety Management Plan. Managers will:

1. Ensure employees participate in fire safety programs/activities (e.g., orientation, continuing education, fire drills, etc.)
2. Identify and correct hazardous fire safety conditions within their work area.
3. Correct life safety hazards/potential hazards within the system.
4. Complete various life safety reports as requested.

5. Develop as appropriate and review, at least annually, work area specific life safety policies and procedures.

#### Employees

All employees are responsible for supporting the Fire Safety Management Plan. Employees will:

1. Know and follow both system wide and work area specific life safety policies and procedures.
2. Report, and correct when possible, actual/potential life safety hazards.
3. Attend appropriate, required educational programs.

#### **Purpose:**

To prepare a Fire Safety Management Plan for patients and employees within NSS. To familiarize all employees with the fire drill procedure, the Director of Nursing will coordinate fire drills every three months.

Desired outcome:

All staff will respond appropriately in the event of a code red alert or drill.

Definitions:

RACE	PASS
R - Relocate	P - Pull
A - Activate	A - Aim
C - Contain	S - Squeeze
E - Extinguish	S - Sweep

#### **Policies:**

1. All personnel are responsible for knowing the evacuation procedure, the method for activating the fire alarm and the location of the fire extinguisher.
2. The Director of Nursing is responsible for coordination of activities.
3. An Emergency Evacuation Route is located wherever patients may congregate, except restrooms.

#### **Procedures:**

1. Individual Discovering Fire: RACE
2. R: RELOCATE PERSONS AWAY FROM DANGER- Evacuate everyone in immediate danger.

A: ACTIVATE ALARM and PHONE 911 - Warn everyone by initiating fire alarm, if it is not already activated.

C: CONTAIN FIRE/SMOKE BY CLOSING DOORS

E: EXTINGUISH FIRE IF SAFE TO DO SO

3. Know the location of fire extinguisher.

4. Extinguisher operation: PASS

P: PULL the pin

A: AIM at the base of the fire

S: SQUEEZE the handle

S: SWEEP from side to side

5. Charge Person

- i. Turn off oxygen as appropriate.
- ii. Assist with the limited evacuation from the immediate danger area.

6. Evacuation.

- i. Move the patients, visitors and employees from the immediate danger. The manager, in conjunction with the Fire Department will authorize further evacuation.
- ii. All staff and patients will meet at a point specified by the Director of Nursing at the time of evacuation.

7. Fire Drills.

- i. Fire drills will be conducted every three months.
- ii. Fire drills will commence when the Director of Nursing announces "Code Red" along with activating a pull station.
- iii. All steps of the fire drill will be followed by activation and calling 911.

**SUBJECT: BOMB THREAT**

**POLICY NUMBER: 7.2.4**

**Policy:**

Receipt of Bomb Threat (Telephone Communication):

1. Should a bomb threat be received by telephone, the person taking the call shall IMMEDIATELY institute the following procedures and complete a Record of Bomb Threat:
  - a. Remain calm. DO NOT panic.
  - b. Keep the caller on the line as long as possible.
  - c. Record, as near as possible, every word spoken by the person calling.
  - d. Listen for any strange or unusual background noises such as music playing, motors running, traffic sounds, etc., which might be helpful in providing clues to determine from where the call was made.
  - e. Determine whether the voice is male or female, familiar or unfamiliar, and listen for any accents, speech impairments, nervousness, etc.
  - f. Record as much information as you possibly can. You may not be able to get everything, but do get all you can.
2. Immediately after the caller hangs up, call 911 and announce "Code Black".
3. Once the Police Department has been notified and the announcement made, contact the following and relay to them the information received:
  - a. Fire Department
  - b. Administrator
  - c. Director of Nursing

**Evacuation Procedures:**

- a. When a bomb threat has been received by this facility, patients shall be evacuated until a place designated within the facility has been secured by a search team. Patients and personnel shall remain in the secured area until an ALL CLEAR has been given.
- b. The Nurse Manager shall assign one personnel the duties of removing the patient's medical records. All such records shall be taken to an area designated by the person in charge.
- c. Personnel who are assigned shall be responsible for assuring that exit routes are safe.

- d. One person must remain at the assembly area to assure that everyone remains in the area. DO NOT let anyone return to the building until ALL CLEAR as been announced.

#### Availability of Equipment:

1. Keys:
  - a. All keys are located with management staff.
  - b. The Director of Nursing shall make available to search teams all combinations to locked rooms being searched.
  - c. The Director of Nursing shall assist search commanders during the search so that his/her knowledge of the keys and floor area can be used to expedite the search.
2. Portable Oxygen Tanks:
  - a. Crash Cart Kit

#### Law Enforcement Responsibilities:

- a. Immediately upon arriving at the scene, the person in charge shall relinquish all authority for the building search to the search commander and provide any assistance or information needed.
- b. The local law enforcement agency, having jurisdiction over such matters, shall be responsible for the orderly search of the building and investigation of bomb threats received.

#### Search Teams:

- a. The on scene commander shall assign or designate a person(s) of this facility to assist in the search when deemed necessary.
- b. This facility shall authorize the use of its employees to assist the search commander. However, employees shall have the right to refrain from assisting in the search if they so choose.
- c. Any employee(s) so designated to assist in the search shall answer fully any questions posed by the search commander and provide any information requested.
- d. Each search team shall have a law enforcement official designated as the team leader and all instructions issued by the team leader shall be followed completely.

#### Searching of Premises:

- a. Once search teams have been organized, a thorough search of the building and grounds shall be made.



- b. During the search, particular attention shall be given to all accessible areas to the general public, i.e.; windows, behind shrubbery, platforms, lobbies, waste cans, restrooms, ceiling lights, corridors, closet areas, storage areas, etc.

#### Locating Suspicious Objects:

- a. It is imperative that you remember you are only employees involved as search members in the search. It must be emphasized that your mission is only to search for and report suspicious objects.
- b. Should a suspicious object be located, DO NOT move, jar or touch the object or anything attached to it. Leave it exactly the way you found it.
- c. Immediately upon discovering a suspicious object, notify your search team leader and follow all instructions.
- d. Once the search commander or search team leader has arrived at your location, the decision shall be made as to continue searching for other objects or not.

#### Removal of Suspicious Objects:

- a. Once the search is completed, or has been terminated by the search commander, all employees participating in the search shall leave the premises and return to the assembly areas designated during the evacuation process unless otherwise instructed by the search commander.
- b. Only authorized law enforcement officials shall remain in the building during the removal of the suspicious object(s) and such agencies shall direct the removal as quickly as possible.
- c. A preselected area, designated for removing the object(s) found, shall be designated by the search commander prior to the removal of such objects(s). This area shall be away from designated assembly areas, as many buildings as possible, and shall be kept clear of all unauthorized personnel at all times.

#### All Clear Signals:

- a. After the search has been completed an ALL CLEAR shall be announced after a confirmation has been obtained from the Police Department or Fire Department stating the building has been searched and nothing found.

#### Telephone Procedures:

- a. The person answering the telephone SHALL NOT give out any information, unless so authorized, concerning the bomb threat to any caller.

Publicity:

- a. Publicity shall be avoided as much as possible for this only generates a tendency to create additional threats.
- b. Only the Administrator, or his/her designee, shall answer questions concerning this matter, and only to those persons with a need-to-know basis.

Damage:

- a. Should this facility be damaged by an explosion and individuals are injured, call 911 for an ambulance if one not already present for transfer to hospital.

**SUBJECT: TERRORIST/MILITARY ATTACKS**

**POLICY NUMBER: 7.2.5**

**Purpose:**

To minimize any danger to life and property resulting from a terrorist or military attack.

**Policy:**

When an attack is pending, all available resources will be used to protect patients, staff, and visitors.

**Procedure:**

1. The Director of Nursing will be responsible for notifying patients, staff, and visitors of an impending attack.
2. The Director of Nursing and/or Administrator will decide whether it is safe to evacuate the facility.
3. If not safe, all staff, patients and visitors who are able, will secure the facility and seek cover.
4. Combustible gas valves will be shut off and any combustible chemicals will be placed into a neutral area, by selected personnel.
5. Staff will assist any persons who are disabled to safety.
6. If any individuals are injured, the medical and nursing staff will triage them, and implement cardiopulmonary resuscitation, if necessary, until the injured can be transported per ambulance.

**SUBJECT: NATURAL DISASTERS****POLICY NUMBER: 7.2.6****Earthquake**

An earthquake will be felt as a trembling in the ground or floor.

1. If caught outside remain outside. Protect yourself from falling items. Stay away from glass, utility poles, walls, downed wires and other objects that might fall.
2. If indoors remain indoors and seek shelter in the center of the building or under a secure doorway
3. Staff should also assign persons to assist disabled ("special need") patients in case an evacuation becomes necessary.

**Flood:**

1. If a flood occurs and time allows, staff will turn off utilities, oxygen valves, and disconnect electrical equipment. DO NOT disconnect equipment if you are wet or standing in water.
2. The Director of Nursing or Administrator will give instructions to evacuate the facility. Staff will assist disabled persons to evacuate. Individuals will be instructed not to walk or drive through moving water.
3. The Director of Nursing will lead everyone to a place of highest elevation, where everyone will be safe from flood waters.

**SUBJECT: FACILITY EVACUATION:****POLICY NUMBER: 7.2.7****Purpose:**

To provide guidelines for facility evacuation and ensure the safety of patients, staff, and visitors.

**Policy:**

1. Emergency Evacuation Routes will be posted wherever patients may congregate, except the bathroom.
2. All personnel will be responsible for familiarizing themselves with the routes.

**Procedure:**

1. The Director of Nursing will assess the situation and designate a safe area to meet. The predetermined location is the south end of parking lot
2. Staff will assist patients and visitors as necessary.

3. Prior to evacuation, the Director of Nursing will do a head-count.
4. Everyone will evacuate according to the posted Emergency Evacuation Routes.
5. All doors will be closed upon exiting.
6. Everyone will meet at the designated meeting point- and the Director of Nursing will do a head count to ensure everyone has evacuated safely.

The Director of Nursing, or emergency personnel if available, will give the "All Clear" to return to the facility.

**SUBJECT: PATIENT SAFETY PLAN**

**POLICY NUMBER: 7.2.8**

**Introduction:**

Safety at NSS 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, NSS 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 NSS'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 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 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, NSS 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. NSS 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 Safety Committee.
- 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

NSS defines medical/health care errors as defined by State regulation:

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."

It includes physical or mental damage that substantially limits one or more of the major life activities of an individual in the short term, which may become a disability if extended long term. Further, injury includes a substantial change in the patient's long-term risk status such that care or monitoring, based on accepted national standards, is required that was not required before the event.

**Serious** defined in NQF Appendix B Glossary

*"describes an event that can result in death, loss of a body part, disability, loss of bodily function, or require major intervention for correction (e.g., higher level of care, surgery) (NQF, 2011: B-4)."*

NRS 439.835 requires that medical facilities report sentinel events to the Division of Public and Behavioral Health (DPBH).

**Current Types of Sentinel Events:**

- |   |  |
|---|--|
| <input type="checkbox"/> Surgery on wrong body part           | <input type="checkbox"/> Surgery on wrong patient                      |
| <input type="checkbox"/> Wrong surgical procedure             | <input type="checkbox"/> Retained foreign object                       |
| <input type="checkbox"/> Intra- or post-operative death       | <input type="checkbox"/> Contaminated drug, device, or biologic        |
| <input type="checkbox"/> Device Failure                       | <input type="checkbox"/> Air embolism                                  |
| <input type="checkbox"/> Discharge to wrong person            | <input type="checkbox"/> Elopement                                     |
| <input type="checkbox"/> Suicide                              | <input type="checkbox"/> Medication error                              |
| <input type="checkbox"/> Transfusion error                    | <input type="checkbox"/> Maternal labor or delivery                    |
| <input type="checkbox"/> SSI                                  | <input type="checkbox"/> Neonate labor or delivery                     |
| <input type="checkbox"/> Fall                                 | <input type="checkbox"/> Pressure Ulcer                                |
| <input type="checkbox"/> Wrong sperm or egg                   | <input type="checkbox"/> Lost Specimen                                 |
| <input type="checkbox"/> Electric shock                       | <input type="checkbox"/> HAI-Other                                     |
| <input type="checkbox"/> Wrong or contaminated gas            | <input type="checkbox"/> Burn  |
| <input type="checkbox"/> Restraint                            | <input type="checkbox"/> Introduction of metallic object into MRI area |
| <input type="checkbox"/> Impersonation of healthcare provider | <input type="checkbox"/> Abduction                                     |
| <input type="checkbox"/> Sexual assault                       | <input type="checkbox"/> Physical assault                              |
| <input type="checkbox"/> CLABSI                               | <input type="checkbox"/> CAUTI   |
| <input type="checkbox"/> VAP                                  |  |

**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.

**Examples of Sentinel Events /Surgical or Invasive Procedure Events**

- ☐ "Surgery or other invasive procedure on the right body part but on the wrong location/site on the body (NQF, 2011: A-2)."
- ☐ "Surgical procedures (whether or not completed) initiated on one patient intended for a different patient (NQF, 2011: A-3)."
- ☐ "Insertion of the wrong medical implant into the correct surgical site(NQF, 2011: A-3)."

**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.

**Examples of Sentinel Events / Product or Device Events**

- ☐ "Occurrences related to use of improperly cleaned or maintained device (NQF, 2011: A-5)."
- ☐ "High-risk procedures, other than neurosurgical procedures, that include, but are not limited to, procedures involving the head and neck, vaginal delivery and caesarean section, spinal instrumentation procedures, and liver transplantation (NQF, 2011:A-6 )."
- ☐ "Low-risk procedures, including those related to lines placed for infusion of fluids in vascular space (NQF, 2011: A-6)."

**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.

### **Examples of Sentinel Events/Care Management Events**

☐ "Occurrences in which a patient dies or suffers serious injury as a result of failure to administer a prescribed medication (NQF, 2011: A-9)."

☐ "Occurrences in which a patient dies or suffers injury as a result of wrong administration technique (NQF, 2011: A-6)."

☐ "Occurrences in which a patient is administered an over- or under-dose of a medication including insulin, heparin, and any other high alert medication including but not limited to medications listed on the Institute for Safe Medication practices "High Alert Medication List" (NQF, 2011: A-9)."

### **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.

#### **Examples of Sentinel Events/Environmental Events**

- ☐ "Patient death or injury associated with unintended electric shock during the course of care or treatment (NQF, 2011: A-13)."
- ☐ "Staff death or injury associated with unintended electric shock while carrying out duties directly associated with a patient care process, including preparing for care delivery (NQF, 2011: A-13)."
- ☐ "Instances where physical restraints are implicated in the death e.g., lead to strangulation/entrapment, etc. (NQF, 2011: A-14)."

#### **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.

#### **Examples of Sentinel Events/ Potential Criminal Events**

- ☐ "Those without licensure to provide care given (NQF, 2011: A-16)."
- ☐ "Those with licensure who represent themselves and act beyond the scope of their licensure (NQF, 2011: A-16)."
- ☐ "Removal of a patient/resident, who does not have decision making capacity, without specific notification and approval by staff even when the person is otherwise authorized to be away from the setting (NQF, 2011: A-16)."

#### **The importance of the completion of the Sentinel Event Forms**

- ☐ The Sentinel Event Forms are updated and reformatted with every refinement in the NRS that occurs. The appropriate form must be used in conjunction with the date of the Sentinel Event.
- ☐ When completing a form, all required fields should be populated before submission of the form. This allows for the Division to enter the information into the database on a consistent basis with a higher accuracy rate at the time in which the yearly Summary Reports are submitted for review by the Board of Health.

**The date of event is the date when:**

- ☐ The event occurred.
- ☐ A staff member can best place the patient exposure or incident in time.

31 of 41

- ☐ The date the facility became aware of an event is the date when:
- ☐ A member of the facility staff learned of the event

**Mandatory Reporting of Sentinel Events: Reporting Timeline**

- ☐ **0-24 hrs.** An employee must report a sentinel event to the Patient Safety Officer.
- ☐ **0-7 days.** The Patient Safety Officer must notify the patient that they were involved in a Sentinel Event.
- ☐ **0-14 days.** A Patient Safety Officer must report event to the DPBH.
- ☐ **0-24 hrs.** An employee must report a sentinel event to the Patient Safety Officer.
- ☐ **0-13 days.** A Patient Safety Officer must report event to the DPBH.
- ☐ **0-45 days.** The medical facility must conduct an investigation of the causes and/or contributing factors or both of the sentinel event.

*Recommended Citation: Office of Public Health Informatics and Epidemiology. Nevada Division of Public and Behavioral Health. 2013 Past to Present Sentinel Event Training Presentation. Carson City, Nevada. September 2013.*

Prioritization of Safety Improvement Activities:

In a continuing effort to prevent errors and improve patient safety, NSS '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. NSS's progress with Patient Safety initiatives is evaluated and actions are planned based on the conclusions and recommendations forwarded to it by the Quality Assurance Committee.

#### Quality Assurance Committee

The Quality Assurance 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 is responsible for:

- Enhancing NSS commitment to patient safety
- Facilitating and coordinating patient safety activities.

**SUBJECT: PATIENT SAFETY**

**POLICY NUMBER: 7.2.9**

#### **Purpose:**

To identify and eliminate potential safety hazards, thereby reducing risk to patients, personnel, and visitors.

#### **Policy:**

Patient safety refers to a systematic program to minimize preventable physical injuries, accidents, and undue psychological stress during the visit. The nursing practice for safety standards is as follows:

1. The procedure nurse always identifies the patient using two patient identifiers.
2. Staff shall use only acceptable abbreviations for medication orders.

3. Patients are on beds which are at the lowest level, with the side rails up at all times when unattended or until discharge criteria is met.
4. 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 year thereafter, by a CME.
5. Vendor representatives are not used as the sole source for clinical education.
6. Flammable solutions (i.e. alcohol) are not to be utilized when electrocautery is in progress.
7. All Biohazardous wastes, including glass, are placed in the special collection container marked "Biohazardous Waste" and disposed of by a contracted service provider.
8. Under normal conditions, extension cords shall not be used. Temporary use of extension cords may be permitted under specified conditions and with proper approval. Use of adaptors within the Center is prohibited.

**SUBJECT: OXYGEN ENRICHED ATMOSPHERE (OEA)**

**POLICY NUMBER: 7.2.10**

**General Information:**

Nitrous oxide and oxygen can cause an oxygen-enriched atmosphere.

- An OEA makes fires start easier.
- In an OEA fires burn much faster.
- Even flame-resistant materials burn vigorously in an OEA.
- An OEA makes fires difficult to extinguish.
- An OEA usually occurs in confined areas, such as under drapes.

**Prevention:**

1. Fire Prevention practices are the most important tools in stopping a fire from starting. The following represent safety tips when working in oxygen enriched atmosphere.
  - Be careful with chemicals and aerosols that contain flammable ingredients.
  - Keep control of high-energy devices that could ignite fires.
2. A fire in an OEA will spread quickly. All personnel need to be aware of fire fighting practices. If a fire occurs, R.A.C.E. protocol, which is outlined in the Fire Safety Management Plan, shall be adhered to, when managing a fire.

**SUBJECT: PORTABLE HEATERS**

**POLICY NUMBER: 7.2.11**

**Purpose:**

Portable heaters pose a fire and electrical threat to patients and staff.

**Policy:** Portable heaters are strictly prohibited. No portable external heating sources are allowed in NSS.

**SUBJECT: CONTAMINATED PATIENTS****POLICY NUMBER: 7.2.12****Purpose:**

To protect staff and patients from Nosocomial infections.

**Policy:**

1. NSS will not admit nor perform procedures on the following patients:

- Active TB or suspected TB.
- Neutropenic patients.
- Patients requiring isolation.
- Patients suffering from biological, chemical, radioactive diseases that are active and may pose a threat to staff and other patients in the facility.

**SUBJECT: CHEMICAL SPILLS:****POLICY NUMBER: 7.2.13****Purpose:**

To establish a policy for the effective response to spills and releases of hazardous chemicals and hazardous wastes, this will minimize the threat to human health and the environment.

**Policy:**

NSS is committed to taking all reasonable and necessary steps to protect human health and the environment in the event of spills and releases of hazardous chemicals. Of paramount importance are the health and safety of employees, patients, and visitors. Due regard is also given to protection of the environment, natural resources, and property.

**Definitions:**

**Hazardous Chemical:** any chemical product, substance, solution, or mixture that is labeled or identified as hazardous to humans and/or the environment. These include, but are not limited to, all products and dilutions listed as hazardous on the product's Material Safety Data Sheet (MSDS) or label, mixtures that contain greater than or equal to 1% by weight of a known hazardous chemical and other known hazardous chemicals.

**Hazardous Waste:** any chemical hazardous waste as so defined in the federal Title 40 Chapter 1 Subchapter 1 Solid Waste Regulations. These include heavy metals, strong acids and alkalis, solvents and reactives and include chemicals which are the byproducts of procedures or tests, expired chemicals,

chemicals for which there is not useful purpose or intent, and certain materials and used reagents intended for reuse or recycling (i.e. – solvents), among others

**Procedure:**

1. Hazardous Chemical List

A current list of the hazardous chemical products that are present, or in use, is available to all staff on the MSDS. It contains information on spill response and clean-up information.

2. General Spill Response Procedures

Where practical, employees in the immediate spill area will respond appropriately, contain and/or clean-up a spill, and arrange for proper disposal of the materials. Established protocols or procedures specified in product literature and/or MSDS will be followed.

3. First Aid

Personal safety is the highest priority in any hazardous materials incident. The first action to be taken is to provide first aid to all who need it. In the event that someone is exposed in a spill incident:

- a. Remove all contaminated clothing.
- b. For splashes to the eye, flush the eye(s) with copious amounts of water for a minimum of 15 minutes.
- c. For splashes to the body, flush the area thoroughly with running water or a chemical safety shower for a minimum of 15 minutes.
- d. Immediately report all employee hazardous chemical exposures to the Director of Nursing.
- e. Report all patient exposures to the patient's physician immediately.

4. Chemical Spills

- a. Identify the spilled material.
- b. Move personnel to a safe distance to prevent unnecessary exposure to the hazardous material.
- c. Isolate the area of the spill to a safe distance.
- d. Notify your supervisor or their designee.
- e. Contain the spilled material to prevent it from spreading to clean areas, floor and sink drains, as well as other hazardous materials, especially incompatible substances.

- f. Absorb the materials with a compatible absorbent such as paper towels, pads, dikes, booms, pillows or granular absorbents. Treat acids and caustics with the corresponding neutralizer, if appropriate.
- g. Using the appropriate personal protective equipment, pick up the absorbent and spilled materials and place it in a poly bag or similar appropriate container.
- h. Place broken glass in a sharps container.
- i. Place non-hazardous waste in the trash. Seal the container to minimize odors and vapors, if this is of concern.
- j. Place hazardous waste in a compatible leak-proof container and mark the container with:
  - i. the words "Hazardous Waste".
  - ii. the contents (i.e. - "mercury spill clean-up").
  - iii. the date.
- k. Thoroughly clean and decontaminate the area of the spill before allowing persons back into the site.
- l. Arrange for pick-up of the waste from the spill clean-up or place it in storage, as necessary.
- m. Complete a Chemical Spill Response Report and forward to the Director of Nursing.
- n. Restock all spill response supplies and personal protective equipment as needed.

For spills and leaks that involve fire or explosion, the fire department will be notified immediately. Employees may attempt to extinguish a small fire if they have been trained in the use of portable fire extinguishers.

#### 5. Releases which Threaten the Sanitary Sewer, Soil, or Washes

- a. All necessary precaution should be taken to assure that hazardous chemical and hazardous waste spills do not spill on the ground or enter the sanitary sewer or washes. Backflow Prevention shall inspect the backflow prevention mechanism at least annually.
- b. In the event that a spill threatens to enter a sewer drain, the drain should be plugged or blocked with a dike. Similarly, the path leading to a wash or soil should have a dike to prevent spilled material from flowing onto the ground or entering the wash. Backflow Prevention will be notified immediately.

In the event that material is spilled on the ground:

- a. Contain the spill to as small of an area as possible.
- b. Immediately report the spill to the Director of Nursing.



Material Safety Data Sheets (MSDS):

Distributors are required to provide a current MSDS for each hazardous chemical shipped. This MSDS need only be sent with the initial shipment, unless changes are made.

1. Upon receipt of all MSDS's, the Director of Nursing (or designee) should ensure that all required information is included on the document:
  - a. Product name.
  - b. Chemical name and synonym(s).
  - c. Name, address, and telephone number of manufacturer/supplier.
  - d. Physical data such as boiling point, appearance, odor.
  - e. Fire and explosion hazard information data.
  - f. Reactivity data.
  - g. Health hazard information/exposure limits.
  - h. Primary route(s) of entry.
  - i. First aid information.
  - j. Spill or leak procedures.
  - k. Personal protective equipment to be used.
  - l. Storage and handling information.
  - m. Date of preparation.
2. All employees will have ready access to MSDS at all times.
3. All new employees will be required to review the MSDS prior to handling any hazardous substances.
4. Employees will also receive education when new products/hazards are introduced into their work area.
5. Hazardous Material in-services will be held on an as needed basis.

**SUBJECT: RECALL OF ITEMS:**

**POLICY NUMBER: 7.Q**

Recalled products or supplies will be immediately removed from inventory. Notification can be received from many sources such as Suppliers, Pharmacy Consultant, Med servers, FDA, CDC and state or local sources. Once a recalled item is verified as part of NSS inventories, all Governing Board members and clinical staff will be notified. A binder has been established to track recalled items and if patients are affected or notified as appropriate. Recalled items will be returned or disposition as instructed in recall information guidance.

**SUBJECT: SMOKING:****POLICY NUMBER: 7.2.15**

NSS is a non-smoking facility. "E-Cigarettes" and similar products that emit vapors will be treated as products used for smoking.

**SUBJECT: COMPRESSED GAS STORAGE****POLICY NUMBER: 7.2.16****Purpose:**

To establish the proper method for storage and handling of compressed gases.

**Policy:**

1. Medical gases, including oxygen and non-medical compressed air are stored in the med gas room.
2. The area will be cleaned once per month, using non-flammable materials.
3. Upright cylinders are placed in holders. They will remain capped while not in use.
4. Portable cylinders will be secured in approved holders.
5. When the main oxygen unit is below 1000, no procedures will be scheduled until refill complete.
6. The DON will coordinate with contracted MED/Gas supplier to maintain adequate levels of Med/Gas.
7. Compressed gas cylinder pressures will be checked weekly and on all procedure days and the day prior, to ensure normal levels are maintained, and documented on the Facility Safety Checklist.
8. DON will be responsible for ensuring maintenance on oxygen containers is completed on schedule.

**SUBJECT: HOUSEKEEPING****POLICY NUMBER: 7.2.17****Purpose:**

To ensure proper cleaning procedures.

**Policy/Procedure:**

1. The Procedure room will be cleaned between procedures by staff using disinfectant provided by NSS and antimicrobial wipes from a local supplier. Please see MSDS sheet for specific antimicrobial and antiviral properties.
2. No "DRY MOPPING" is allowed.

Daily cleaning will be performed by third party professional cleaning service. Cleaners will utilize the cleaning checklist provided by DON.

**SUBJECT: APPROVED CHECKLISTS**

**POLICY NUMBER: 7.3A**

# QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN

## Las Vegas Surgery Center

2016

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 and community standards for ambulatory surgical care, this plan allows for a planned, systematic, organization-wide approach to the quality improvement process, reducing risks through an effective risk management plan and 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 and human resources. The overall strategies of the program include

- Improving patient safety and reducing risk to patients,
- Reducing medical/health 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 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 Process
- Quality Studies
- Quality Improvement Process
- Risk Management Strategies
- Patient Safety
- Infection Control Strategies
- Medication Safety
- Radiation Safety

### **Definitions**

**Significant Event/Medical Error (Sentinel Event):** Any unexpected occurrence involving a death, serious physical or psychological injury or risk thereof. Serious injury specially includes loss of limb or function. "Risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome.

**Adverse Event:** Any event where result is not consistent with the desired plan of care and that leads to patient harm not limited to medication error.

**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).

**Root Cause Analysis (RCA):** A method of problem solving that tries to identify the root causes of faults or problems. RCA practice tries to solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing 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 root cause analysis. RCA is typically used as a reactive method of identifying event(s) causes, revealing problems and solving them. The RCA findings are reported at the quality meetings, MEC and GB meetings.

#### **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.

Effective January 1, 2016 Las Vegas Surgery Center shall 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. 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 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**

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/health 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 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 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 and families, 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 and creating a safe environment.

### **Peer Review**

Ambulatory Surgery Centers are required by AAAHC, CMS, and other regulatory agencies to conduct quality improvement and peer review. Peer review activities include ongoing random review, specialty specific review and review of complications. Cases with complications are reviewed by the physicians within the same specialty as the physician under review.

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. 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/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 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 2016, upon approval from the MEC and Governing Body:

Quality Improvement Committee Chair:	The Doctors/administrators' Names have been removed based on NRS 439.843.
Risk Manager:	
Infection Control Coordinator:	
Patient Safety Committee Chair:	

#### **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 during 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 Administrators. 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 for 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
  - "Near miss" event (close call)
  - 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 include at a minimum:
  - 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 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 b corporate
- Patient complaints ( response and corrective action)
- Physician complaints ( response and corrective action)

### **Patient Flow -- Choose applicable utilized at your Center**

- OR start "on time" percentage of first 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**

- Appropriate follow through on obtaining pre-op diagnostic studies per anesthesia guidelines and follow up on abnormal reports
- Pre op instructions
- DVT assessment

### **Intra-op Care and Processes**

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

### **Complications/Adverse Events**

- Unexpected complications
- Post op DVT's/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 and review of all autopsies
- Falls
- Burns
- Loss of Vision

**Resuscitation**

- Code blue drill(s)
- Crash carts, Malignant Hyperthermia carts checked according to policy

**Diagnostics Results**

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

**Medication Usage**

- 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**

- 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
- Appropriate endoscopy re-processing
- Monitoring of temperature of rooms and equipment.
- Monitoring of humidity of designated rooms

**Provision of Care/ Medical Record Review**

- Physician H&P on chart prior to start of surgery
- 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.
- 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

**Safety**

- Surveillance rounds and corrective follow up on deficiencies
- Process for notifying and following through on recalls
- Fire drills

- Emergency preparedness drills
- Infant/child abduction drill
- Sharps prevention program

#### **Radiation Safety**

- Staff and physician training in radiation safety
- 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
- Allergies noted and communicated
- Time out verification for procedures
- Surgical Site marking
- Appropriate use of abbreviations
- Latex allergy precautions
- Falls prevention guidelines
- Close calls
- Hand off communication

### **QUALITY IMPROVEMENT / RISK GOALS**

**In this area please provide the following:**

#### **Summary of goals for 2015:**

**We created a standardized process for medication ordering and delivery in the PACU. This was to reduce medication related post operative complications. We achieved this goal and all staff nurses were involved in the process.**

**We wanted to provide a culture of safety, effective communication and teamwork which is critical in the process to eliminate wrong site, wrong procedure and wrong patient surgeries. This was completed by using the Passport effectively. All staff was trained on the procedural use of this form. We had no wrong sites, lens or procedures.**

**We completed all annual and mandatory drills. Working with the state in the "Great Shake out event", Active shooter drill, Code Adam and Amber drills.**

#### **2016 Division Goals:**

- **To continue to reduce the number of sharp occurrences. (In 2014 the Division reported 20 occurrences and in 2015 the Division reported 17 sharp occurrences.)**
- **To continue to reduce the number of falls. (In 2014 there were 25 falls reported within the Division and in 2015, with the implementation of the falls toolkit, the falls reported decreased to 14.)**
- **To complete the 2016 Risk Reduction Program Initiatives.**
- **To meet the 2016 ASD Clinical Objectives.**

#### **2016 Las Vegas Surgery Center Goals:**

- **To increase staff empowerment to report Close Calls.**

- To increase OR's knowledge of the "Neutral Zone" as in relation to increased (2) sharp occurrences in 2015.
- Identify our IUSS (Immediate Use) rate and implement appropriate action if necessary.

**SAFETY**

ELECTRICAL EQUIPMENT - SAFE USE OF	1
ELECTROSURGICAL UNIT - SAFE USE OF	2
EQUIPMENT MANAGEMENT, MAINTENANCE & REPAIR	5
EQUIPMENT MALFUNCTION	6
EQUIPMENT – USE OF “DIRTY” EQUIPMENT	7
FALLS RISK	8
FIRES IN THE OPERATING ROOM	9
PNEUMATIC TOURNIQUET - SAFE USE OF	13
RADIATION SAFETY	15
RECALL- EQUIPMENT, SUPPLIES AND FOOD	19
SECURITY	20
STORAGE AND HANDLING OF MEDICAL GASESE	21
SUCTIONING EQUIPMENT	22
SYRINGES AND NEEDLES – HANDLING, STORING, MANAGEMENT	23

## **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.

## **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.
- K. During laparoscopic surgery, the ESU shall be used in a manner that minimizes the likelihood of capacitive coupling injuries.

*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.

## **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.

### **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.

## **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)

## **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).

## **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 by utilizing the Morse Falls Risk Assessment.

### **PROCEDURE:**

#### **Standard Fall Risk Interventions:**

- a. Orient patient/family to environment and routines.
- b. Place call light within reach and remind patients to call for assistance.
- c. Ensure that patient bed is in low position and the brake is on.
- d. Place patient's necessary items within reach.
- e. Provide non-skid footwear for patient as needed.
- f. Minimize environmental trip/slips hazards.
- g. 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.

## **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*

## TYPICAL COEXISTING INGREDIENTS THAT COULD CAUSE AN OPERATOR ROOM FIRE

### OXIDIZERS

Oxygen      Nitrous Oxide

### IGNITION SOURCES

Electrosurgical Units	Fiberoptic Light Sources
Electrocautery Units	Static Discharge Spark
(both battery and	Incandescent Spark
line operated)	
Surgical Lasers	

### COMBUSTIBLE SUBSTANCES

<i>Patient:</i>	<i>Dressings</i>
Hair	Gauze
G.I. Tract Gases	Sponges
	Adhesive tape
	(cloth, plastic)
<i>Prepping Agents</i>	<i>Ointments:</i>
Degreasers:	Collodion
Ether	Petrolatum (petroleum jelly)
Acetone	Tincture of benzoin
(Freon is non-flammable)	Aerosols (e.g., AeroPlast)
Aerosol adhesives	Paraffin
Alcohol (also present when	White wax
spilled from gut suture	
packets during opening)	
Tinctures	<i>Plastic/Rubber Products:</i>
Hibitane (chlorhexidine	Blood pressure and tourniquet
digluconate)	cuffs
Merthiolate (thimerosal)	Gloves
	Stethoscope tubing
<i>Linens:</i>	<i>Anesthesia Components:</i>
Drapes (non-woven, woven, adherent)	Masks
Gowns	Airways
Masks	Endotracheal tubes/
Hoods	Breathing circuits

## **PNUEMATIC TOURNIQUET SAFETY**

### **POLICY:**

Should a pneumatic tourniquet be utilized, the tourniquet will be used in a manner that reduces the potential for patient injury.

### **PROCEDURE:**

A. The pneumatic tourniquet shall be tested, maintained, inspected, and cleaned according to manufacturer's written instructions before and after use.

1. Equipment malfunction and/or damage is to be reported immediately to the Clinical Supervisor.
2. If using a disposable tourniquet, discard after use unless the manufacturer recommends that it can be resterilized. Reusable cuffs and bladders shall be cleaned, rinsed, and dried according to the level of contamination and manufacturer's instructions.
3. The tourniquet cuff shall be protected adequately from contamination during surgery; therefore, washing is the only decontamination procedure indicated.
4. The frequency, method, and criteria for pneumatic tourniquet testing shall be established according to manufacturers written instructions.
5. Documentation shall be maintained to reflect the date of inspection, preventive maintenance, and status of equipment.
6. When information is received that the pneumatic tourniquet medical device has malfunctioned, resulting in patient or personnel injuries, the information shall be reported as required by the Safe Medical Devices Act Of 1990.

B. The pneumatic tourniquet shall be used as designed and in a manner that reduces the risk for patient injury.

1. Tourniquet cuff length and width shall be individualized, taking into consideration the size and shape of the patient's limb and the specific demands of the procedure. The widest cuff possible, based on *the* appropriate tourniquet length, shall be selected.
2. Skin integrity under the tourniquet shall be maintained. Wrinkle-free padding will be wrapped smoothly around the limb as high on the extremity as possible, being careful not to pinch the skin folds where the tourniquet is applied (unless contraindicated by the manufacturer or the surgeon). Once inflated the cuff shall not be readjusted.
3. The upper arm and thigh tourniquet cuffs shall be positioned on the limb at the point of maximum circumference according to manufacturers' written instructions for use.
4. Protection shall be provided to keep fluids from collecting under the tourniquet cuff.

5. A rubber bandage shall be available for exsanguination; inflation of the tourniquet must be done rapidly.
  6. When the cuff is inflated, the pressure gauge shall be clearly visible and checked according to manufacturers' written instruction.
  7. Tourniquet inflation pressure shall be kept to a minimum. The pressure depends on the patient's age, systolic blood pressure, tourniquet width, and circumference of the extremity. The surgeon shall determine the size and position of the tourniquet cuff as well as the pressure setting-
  8. Tourniquet inflation time shall be kept to a minimum. The surgeon shall be informed of the duration of tourniquet time after one hour has elapsed and each half-hour thereafter.
  9. Documentation during the use of the pneumatic tourniquet shall include:
    - Cuff location
    - Skin protection/padding/stockinette
    - Cuff pressure
    - Time of inflation and deflation
    - Skin and tissue integrity under the cuff before and after the use of the pneumatic tourniquet
    - Assessment and evaluation of the entire extremity
    - Identification/serial number and model of the specific tourniquet
    - Identification of the person who applied the cuff.
- D. Perioperative personnel shall be aware of the most common complications and prevention strategies when using a pneumatic tourniquet.
1. Safety measures to prevent injury shall include:
    - Performing a complete patient evaluation preoperatively
    - Monitoring the tourniquet inflation time
    - Monitoring the pressure display to ensure that it accurately reflects the pressure within the cuff bladder
    - Using the minimal effective pressure required to suppress arterial circulation
    - Ensuring proper fit of the cuff on the extremity
    - Applying the cuff to the limb with care and attention
    - Following manufacturer's written instructions
- E. Personnel shall demonstrate competency in the use of the pneumatic tourniquet.
1. Perioperative personnel shall be instructed in the proper operation of the pneumatic tourniquet before use.

## **RADIATION SAFETY**

### **Purpose:**

To provide a safe environment for patients, physicians and employees during fluoroscopy procedures.

### **Policy:**

Only Radiologic Technologist or Physician who operates or directs operation of fluoroscopy equipment must possess the Radiology Supervisor and Operator Certificate or a Fluoroscopy Supervisor and Operator Permit from the California Radiologic Branch. A copy of the certificate will be in the staff members file.

1. The CRT or Physician can do one or more of the following during fluoroscopy of a patient:
  - Position the patient.
  - Positions the fluoroscopy equipment
  - Selects exposure factors
2. Radiologic Technologists shall not independently perform diagnostic fluoroscopic procedures for the purpose of interpretive diagnosis. Fluoroscope for diagnosis is performed by a Radiologist or a credentialed physician
3. If a nurse or surgical tech doesn't have a fluoroscopy certificate or permit. They can only do the following under the supervision of the licensed operator:
  - Placing the patient on the table,
  - Moving the C-Arm from storage to the operating room and moving the equipment over the patient,
  - Plugging in and turning on the power for the fluoroscopy unit

The Radiation Safety Officer (RSO) named on the facility's registration on file shall ensure that radiation safety activities are being performed in accordance with approved procedures and regulatory requirements in the daily operation. The RSO'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.
- The patient will be protected from unnecessary radiation exposure.
- Measures taken to protect patients during the procedure from the risks of direct and indirect radiation exposure will be documented on 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.
- 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 to a minimal 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, 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.
- Occupational dose to the embryo or fetus of an occupationally exposed health care worker who has declared her pregnancy must not exceed 0.5 rem during the entire gestational period.
  - Occupational dose will be uniform over time and not all at once (ie, at one point in the gestational period).
  - Deep-dose equivalent of the declared pregnant health care worker must be used as the dose to the embryo or fetus.
- Maternity aprons must be easily identifiable and available to pregnant health care personnel.
- Pregnant health care personnel must wear maternity aprons to decrease the amount of radiation to the embryo or fetus.

### ***Shielding Devices***

- Before use, newly purchased leaded devices will be tested for ant 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.

### ***Radiation Monitors***

- Health care personnel who are involved routinely in fluoroscopic procedures will wear at least one radiation dosimeter badge.
- Health care personnel who are pregnant will wear radiation dosimeters at the waist and readings will be performed monthly.

### ***Documentation***

- Any x-ray procedure performed in the operating room must be documented in the fluoroscopy log.
- The RSO will provide documentation of records such as Notice to Employees posting and Notice of Registration.
- An incident report will be completed for any procedure in which radiological exposure has occurred and wherein the procedures and interventions in this policy were not followed.
- Documentation of the readings of the dosimeters will be provided on a quarterly basis and maintained by the RSO.
- 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.

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. The in-service will be provided by the Radiation Safety Officer.

*References: Recommended practices for reducing radiological exposure in the perioperative practice setting. In: Perioperative Standards and Recommended Practices. Denver, CO: AORN, Inc; 2013:295-304*

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 X-ray RSO, and promptly take appropriate corrective action to ensure against recurrence. This corrective action may include reassigning personnel duties. The X-ray RSO 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



## **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. There shall be an inventory list of the equipment and supplies.
2. The Clinical Supervisor will register with FDA Recalls & Alerts website to monitor any notifications.
3. 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.

## 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 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 Medical Director 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. During hours of non-operation, security is provided by a monitored security system.
4. 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.

## STORAGE AND HANDLING OF MEDICAL GASES

### 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 in storage and doubled chained to the wall.
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.
7. Appropriate signage shall be placed with the safety warnings.

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

## SUCTIONING EQUIPMENT

### POLICY:

The Clinical Supervisor is responsible for the correct functioning of the suction system. The Clinical Supervisor shall familiarize himself/herself with the suction machines and be aware of how they perform.

### 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 the procedure, if suction bottles have been used, the suction bottles containing aspirate (plus and/or germicide) shall be emptied into the toilet.
- c. If non-disposable suction bottles are used, 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.

## **SYRINGES AND NEEDLES – HANDING, STORING, MANAGEMENT OF**

### **POLICY**

Syringes shall be managed in accordance with all applicable regulations governing syringes in order to maintain safety for patients, visitors, administrative and medical staff.

### **PROCEDURE**

1. All syringes and needles shall be kept in locking enclosures (for example, cabinets, drawers). Cabinets shall be kept locked during business hours to avoid any potential patient tampering.
2. All used syringes and needles shall be disposed of in accordance with regulations governing medical waste (see Infection Control section).
3. Syringes and needles are considered to be sterile supplies and must be stored with sterile supplies, segregated from non-sterile supplies. Syringes and needles will be removed from their “outside” shipping boxes before being placed in the sterile supplies storage area(s).
4. Syringes and needles will be ordered under the direction of the Clinical Supervisor.
5. Receipt of syringes and needles shall be handled in the same manner as all other supplies (checking packing slip to purchase order, if applicable, comparing to invoice, comparing invoice price to agreed-upon or contracted price).
6. The practice of pre-drawn syringes is discouraged, but when vital to the delivery of quality of care, will be performed in accordance with standard safety practices such as: Medications drawn into a syringe must be labeled with the name of the drug, the strength, the date and the initials of the qualified medical staff member drawing up the medication. The medication and syringe will be properly disposed of at the end of the day if not used.

## **Barton Health 2016 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 team work, 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 Patient Safety Officer (PSO), 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 Patient Safety Officer 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 PSO involves

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, Patient Safety Officer, Director of Risk Management, 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 through The Joint Commission.

### **Scope of the Patient Safety Plan**

The Joint Commission, CDPH, NRS, Centers for Medicare and Medicaid Services (CMS) guidelines and other regulatory agencies provide the defining framework for patient safety events. The Patient Safety Officer 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 as collected by the Risk Management Department 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 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 health care 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.

## 2015 Priority Review

, Barton Health continued to prioritize NPSG.06.01.01 focusing on alarm system safety in 2015. An intense alarm review was completed with biomedical equipment default parameters adjusted after consultation with medical and clinical staff and consideration of patient risk, alarm necessity, and best practices and guidelines. A clinical alarm management policy was developed.

Barton Health continued to ensure the transition to the new ISO (International Organization for Standardization) connector standards was an organizational high priority in accordance with California AB 1867 and Joint Commission Sentinel Event Alert 53. This priority will continue into 2016 as new connectors become available from manufacturers as well as misconnecting intravenous, enteral feeding and epidural lines per California Health and Safety Code 1279.7.3..

## High Priorities for 2016

In 2016, sepsis will remain Barton's Failure Mode and Effect Analysis (FMEA). Work on this FMEA will finish up in the first half of the year.

Monitoring of mental health and pediatric patient issues will be ongoing during the year. Attention will be directed toward system needs as well as staff education and training to ensure safe patient care.

Efforts will also focus on increasing patient safety presence in all Barton Health physician practices and off-site clinical departments through increased site visits by the patient safety team.

## 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.
- **Near Miss/Good Catch/Close Call:** Any patient safety event that did not reach the patient...
- **No-Harm Event-** a patient safety event that reaches the patient but does not cause harm.
- **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.
- **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 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 Quality Council, Interdisciplinary Collaborative Care Team, and Board Quality Committees.
- 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 Healthcare 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 immediately 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. 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
- Abduction of any patient receiving care, treatment, and services
- Discharge of an infant to the wrong family
- 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
- 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
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- 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
- 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 any of the following: Permanent harm or severe temporary harm\*.

\*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 report Sentinel Events to The Joint Commission within the 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.
23. A patient death or serious disability associated with the use of restraints or bedrails.
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.
28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

Measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines shall also be included in analyses.

#### *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 health care-acquired conditions (HCAC) and other provider-preventable conditions (OPPC). California HCACs and OPPCs are reported to the Department of Health Care Services within five working days. 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 hyperosmolarity
- 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
- For non-pediatric/obstetric population, deep vein thrombosis (DVT)/ pulmonary embolism (PE) resulting from:
  - Total knee replacement
  - Hip replacement

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

### **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 (PSO). 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 Patient Safety Officer, Risk Manager, or Director of Quality and includes team members either directly or indirectly involved in the event. Members from uninvolved departments may be invited to provide additional information. 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. To ensure consistency, The Joint Commission's Root Cause Analysis and Action Plan template is utilized as a framework.

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 Officer.

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 Director of Risk Management, Patient Safety Officer, or Director of Quality 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 Healthcare System's patients.

The Patient Safety Committee is a standing committee of the Medical Staff and is comprised of the Chief Medical Officer, Chief of Staff, Physician Director of the Emergency Department, Hospitalist Director, Trauma Medical Director, Nurse Director of the Emergency Department, Patient Safety Officer, Director of Pharmacy, Director of Intensive Care Unit, Director of Risk Management, Vice President of Nursing and Director of Quality. Ad Hoc members are invited as appropriate.

The Patient Safety Committee shall review and discuss codes, hospital deaths, Rapid Response Team activations (including near codes), 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, Patient Safety Officer, 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 Officer 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 Patient Safety Officer 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), Patient Safety First, 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 Quality Council and Board Quality Committee on a biannual basis. Measure of success for compliance on each standard's requirement is expected to be 90% (ninety percent) and above. Elements falling near or below 90% (ninety percent) are addressed by the appropriate Department Director. The Director 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, 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 Officer.

### *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.)
- 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 December 15, 2015

Board Quality on January 7, 2016

## References

- Agency for Healthcare Research and Quality. (2008). *The patient safety and quality improvement act of 2005*. Retrieved November 30, 2015 from <http://www.ahrq.gov/policymakers/psoact.html>
- California Department of Health Care Services. (2013). *Provider-preventable conditions*. Retrieved November 30, 2015, from [http://www.dhcs.ca.gov/individuals/Pages/AI\\_PPC.aspx](http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx)
- California Department of Public Health (n.d.). *HSC Code § 1279.6*. Retrieved November 30, 2015 from <http://codes.lp.findlaw.com/cacode/HSC/1/d2/2/3/s1279.6>
- California Department of Public Health (n.d.). *HSC Code § 1279.7*. Retrieved December 14, 2015 from <http://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-1279-7.html>
- California Department of Public Health. (2009, November 19). *AFL 09-41 Health facility connection port prohibitions*. HSC 1279.7. Retrieved November 30, 2015, from <http://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-09-41.pdf>
- Centers for Disease Control and Prevention's National Healthcare Safety Network. (2014). *Healthcare-associated infections (HAIs)*. Retrieved November 30, 2015 from <http://www.cdc.gov/hai/>
- Nevada Division of Public and Behavioral Health (2015). Sentinel event registry. Retrieved December 2, 2015 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
- The Joint Commission Standard LD.04.04.05
- The Joint Commission. (2016). *National Patient Safety Goals*. Retrieved November 30, 2015 from [http://www.jointcommission.org/standards\\_information/npsgs.aspx](http://www.jointcommission.org/standards_information/npsgs.aspx)
- U. S. Department of Veterans Affairs. (2015). *Root cause analysis tools*. Retrieved December 7, 2015 from [http://www.patientsafety.va.gov/docs/joe/rca\\_tools\\_2\\_15.pdf](http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf)

## **Lake Tahoe Surgery Center Patient Safety Plan 2016**

The Lake Tahoe Surgery Center Patient Safety Plan provides the patient and personnel with the foundation to proactively reduce the potential for error and harm. This appendix to the organizational Patient Safety Plan encompasses requirements for the Nevada based Lake Tahoe Surgery Center, a department of Barton Health.

### **Objectives**

- To control known and potential safety hazards to patients, visitors, and staff.
- 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.
- To create an culture in which patients, visitors and employees can identify and manage actual and potential risks to patient and staff safety.
- 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.
- To develop an environment that supports sharing of knowledge to effect behavioral changes in itself and other healthcare organizations to improve patient safety.

### **Goals**

- Strive for zero harm
- Provide education to all staff on the elements of the Lake Tahoe Surgery Center Patient Safety Plan.
- In-service all personnel on the use and completion of event reports.
- Reduce the risk of safety related incidents by proactively evaluating systems in place and making any necessary changes.
- Provide communication and education to patients relating to their care.

### **Organization and Responsibility**

The Patient Safety Officer 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.

### **Lake Tahoe Surgery Center Patient Safety Committee**

The Lake Tahoe Surgery Center Patient Safety Committee is a subcommittee of and shall report to the organizational Patient Safety Committee which reports to Board Quality and the Governing Board.

The Lake Tahoe Surgery Center Patient Safety Committee's membership is composed of the Patient Safety officer; Infection Preventionist; three facility health care providers including at least one medical, one nursing and one pharmaceutical representative; one member of the executive or governing body.

This committee shall meet once per quarter and review the following:

- Reports from the Patient Safety Officer on any sentinel events and actions taken
- Evaluate actions of the Patient Safety Officer in relation to sentinel events

- Review and evaluate the quality of measures carried out to improve patient safety
- Review and evaluate the quality of measures carried out to prevent and control infections
- Make recommendations to the Patient Safety Committee, executive or governing body to reduce the number and severity of sentinel events and infections that occur
- Ensure the number of sentinel events, number and severity of infections and recommendations to reduce the number and severity of sentinel events and infections are reported to the Governing Board through the Patient Safety Committee.
- Adopt patient safety checklists and policies, review these annually and revise the checklists and policies as the Lake Tahoe Surgery Center Patient Safety Committee deems necessary.

The following reports will be submitted:

- Quarterly to the Patient Safety Committee:
  - The number of sentinel events that occurred at Lake Tahoe Surgery Center during the preceding calendar quarter
  - The number and severity of infections that occurred at the medical facility during the preceding calendar quarter
  - Any recommendations to reduce the number and severity of sentinel events and infections that occurred at Lake Tahoe Surgery Center
- On or before March 1 of each year a report to the Division as directed by the Nevada State Board of Health consisting of a summary of the reports submitted by the facility during the immediate preceding calendar year including:
  - The total number and types of sentinel events reported by Lake Tahoe Surgery Center
  - A copy of the most current patient safety plan
  - A summary of the membership and activities of the Lake Tahoe Surgery Center Patient Safety Committee
  - Any other information required by the Nevada State Board of Health concerning the reports submitted by the facility
- On or before July 1 of each year a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care including information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

### **Appointment of Qualified Individuals**

The Patient Safety Officer, with the assistance of the Administrator and Director of Nursing of Lake Tahoe Surgery Center will oversee, monitor and evaluate safety activities, manage the program that measures and analyzes safety levels, and help identify problem areas for correction.

The Patient Safety Officer shall supervise the reporting of all sentinel events; take the necessary action to ensure the safety of patients as a result of a sentinel event investigation; and 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.

The Patient Safety Officer, Administrator and Director of Nursing have the authority to mitigate actual or potentially hazardous conditions that may lead to a sentinel event or patient error and harm.

The Infection Preventionist shall take the following actions:

- Monitor and report to the Lake Tahoe Surgery Center Patient Safety Committee the occurrence of infections to determine the number and severity of infections

- Implement actions to prevent and control infections alleged to have occurred at Lake Tahoe Surgery Center
- Carry out the organizational-wide Infection Control Plan
- Report the occurrences of infections to the Lake Tahoe Surgery Center Patient Safety Committee, organizational Patient Safety Committee, Quality Council Committee and Board Quality Committee

### **Reporting and Investigation**

The Patient Safety Officer and Director of Risk Management shall review all organizational incident reports. Evaluation of the incident, conclusions, recommendations and actions taken will be noted by either the Administrator, Director of Nursing, Patient Safety Officer, Director of Risk Management, or Director of Quality.

All staff receive education on what constitutes an occurrence and completing an event report. Staff will be encouraged to report all occurrences with the understanding that the reporting party will not be 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 or other appropriate authority; notified 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.

### **Sentinel Events**

A sentinel event is an event included in the most current “Serious Reportable Events in Health Care” list published by the National Quality Forum and includes:

- 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
- 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 healthcare 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, 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
- 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
  - A. 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

Sentinel events must be reported to the Patient Safety officer or designee within 24 hours after becoming aware of such an event. The Patient Safety Officer or designee shall report the date, time, and provide a description of the sentinel event to the Division within 13 days after the event. Notification may be done by a representative designated by the Patient Safety Officer, Director of Risk Management, or Director of Quality.

In the case of a sentinel event, a root cause analysis (RCA) is completed by the Patient Safety Officer, Director of Risk Management or the Director of Quality. The RCA shall be conducted with the development and implementation of a plan to remedy the causes and, if identified, contributing factors to the event. The RCA is reported to the Lake Tahoe Surgery Center Patient Safety Committee, Patient Safety Committee, Board Quality and Governing Board.

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 Officer.

As a learning organization, Barton Health focuses on systems and processes, not individuals, during RCA or PI event review.

### **Patient Communication and Education**

Staff, in conjunction with the Lake Tahoe Surgery Center Patient Safety Committee, will develop avenues to communicate and educate patients and family about general safety issues and patient care. Specific areas that may be addressed are:

- Measures utilized by the facility for preventing infections including facility-acquired infections
- Information on determining whether a patient had an infection upon admission to Lake Tahoe Surgery Center, risk factors for acquiring infections and determining whether an infection has been acquired
- Information on preventing facility-acquired infections
- Instructions for reporting facility-acquire infections including contact information for reporting to the Nevada Division of Public Health

Patients involved in sentinel events shall be notified of the event within seven (7) days. Patients involved in facility related infections will be notified of such no later than five (5) days after confirmed diagnosis. Notification may be done by the Patient Safety Officer, Director of Risk Management, or Director of Quality or designee.

### **Patient Safety Checklists, Policies and Procedures**

Policies and procedures will be developed to enhance facility, staff, patient and visitor safety within the facility. The Lake Tahoe Surgery Center Patient Safety Committee will review safety related checklists and policies in accordance with state and organizational requirements. The ultimate responsibility for development and maintenance of current department specific safety policies shall lie with the department directors/managers with the assistance of the Patient Safety Officer, as appropriate.

Adopted checklists provide protocols to improve the health outcomes of patients at the medical facility including:

- Related to specific types of treatment
- Ensuring a sanitary patient care environment
- Patient discharge with instructions concerning prescriptions medications, instructions concerning aftercare, instructions specific to a patient's care after discharge
- Any other checklists that ensure patient safety

Adopted polices include:

- Patient Identification
- Hand Hygiene
- Patient Safety Checklists

- Other patient safety policies as deemed necessary by the Lake Tahoe Surgery Center Patient Safety Committee

Refer to Appendix B for a list of Patient Safety Checklists and Policies for Lake Tahoe Surgery Center

### **Annual Evaluation**

The scope, performance, effectiveness, and outcome of the Lake Tahoe Surgery Center Patient Safety Plan shall be reviewed by the Lake Tahoe Surgery Center Patient Safety Committee, Patient Safety Committee, Board Quality, and the Board of Directors annually or when changes are made.



## Patient Safety Checklists and Policies for Lake Tahoe Surgery Center

<b>Check Lists Include:</b>	<b>Developed</b>	<b>Revisions*</b>	<b>Usage**</b>	<b>Review***</b>
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		Jan 8, 2014	PACU	X
Surgical Safety Checklist (AORN)		December 1, 2015	PRE-OP/OR	X
Environmental Rounds (quarterly)		November 3, 2015	ASC	X
Infection Control Survey (monthly)			ASC	X
Incubation Temperature			STERILIZATION	X
Medication Refrigerator		May 2013	PRE-OP/PACU/OR	X
IVF/Blanket Warmer Temperature		April 2013	PRE-OP/PACU/OR	X
OR Temperature/Humidity		December 18, 2014	OR	X
Washer Sterilizer Cleaning			STERILIZATION	X
Daily, weekly, monthly duties		December 1, 2015	PRE-OP/PACU/OR	X
Crash Cart			NURSING	X
Hand Hygiene Audit			ASC	X
Medication Labeling Audit		Sept 9, 2013	ASC	X
<b>Patient Safety Policies Include:</b>	<b>Developed</b>	<b>Revisions</b>	<b>Usage</b>	<b>Review</b>
Patient Identification			ASC	X
Hand Hygiene			ASC	X
Patient Safety Checklist			ASC	X
Medication Reconciliation			ASC	X
Handoff Communication			ASC	X
Universal Protocol			ASC	X
Safe Preparation and Administration of Medications			ASC	X
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
<b>Summary of Review</b>	<b>Total # developed</b>	<b>Total # revised</b>	<b>Total # Reviewed</b>	
Patient Safety Checklists		5	9	
Patient Safety Policies			18	

\*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



# INSTITUTE OF ORTHOPAEDIC SURGERY

## LIFE SAFETY MANAGEMENT PLAN

### I. Scope of Plan

The Institute of Orthopaedic Surgery 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

IOS 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 IOS 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
- ✚ Risk Management Report
- ✚ Patient / family / vendor complaints
- ✚ Patient Satisfaction Surveys
- ✚ Quality Assurance Committee findings

### **VIII. EVALUATION OF PLAN ACTIVITIES**

IOS 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.

IOS 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.

# **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**

---

## **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**

---

- 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**

---

- 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**

---

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**

---

- 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 1<sup>st</sup> 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**

---

- 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**

---

**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**

---

## 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)**

**Subject: Patient Safety Plan**

**Effective Date 01/2012**

**Revised: 03/2012**

**Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016**

---

- 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**

**Revised: 03/2012**

**Reviewed/Accepted: 03/2012, 7/2013, 03/2014, 03/2015, 01/2016**

---

Adapted from Medical Mutual Template Safety Plan and Nevada State Health Division Regulations

# INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)

## **Policy: Patient Safety Plan**

### **Subject: Fall Prevention and Patient Escort Policy**

**Effective Date: 6/8/2015      Reviewed: 01/2015**

**Page: 1 of 1**

#### **Purpose:**

To establish guidelines to help provide safe patient discharge and reduce/prevent patient falls and injuries.

#### **Policy:**

- A. Staff members will follow established policy and procedures under Section 25 Title: Fall Prevention and Reduction Policy when assessing patients for fall risks and implementing interventions to reduce/ prevent patient falls and injuries.
- B. Once a patient has 1) met all discharge criteria, 2) completed a physician discharge evaluation, and 3) received a signed physician discharge order staff members will physically escort the patient to their vehicle. Staff members will ensure a responsible adult is present for transport and pick-up of patients prior to discharge.
- C. When staff members are physically escorting the patient through the parking area; the staff member **WILL** ensure:
  - 1. The patient's gait and mobility is stable or has returned to pre-procedure mobility levels.
  - 2. Provide physical assistance utilizing an effective number of staff members for safe discharge.
  - 3. A responsible adult driver is present during discharge and will transport the patient home.
  - 4. The chosen path of escort is free of debris, walking hazards, or uneven/unstable footing.
- D. When staff members are physically escorting the patient through the parking area; the staff member will **NOT** allow the patient to:
  - 1. Walk over or travel through unestablished walking paths.
  - 2. Step over or travel through building fixtures, railings, dividers, parking fixtures, plants/ foliage, or areas of construction or renovation.
  - 3. Be unattended in the parking area.

# **INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)**

## **Policy: Patient Safety Plan**

### **Subject: Surgical Safety Checklists**

**Effective Date 01-12**

**Revised:03-12**

**Reviewed: 01/2016**

**Page 1 of 2**

---

## **PURPOSE:**

To establish guidelines to ensure the patient has received proper preparation for an operative procedure

## **POLICY:**

There are two (2) checklists that have been established representing different phases of the patient process from pre-operative to discharge. The "Safety Checklist/Signature Verification" will be filled out by licensed registered nurses (RNs) in the pre-operative and PACU areas. The "Surgical Safety Checklist" will be filled out by the Circulating Registered Nurse in the Operating Room. Any omissions on the "Safety Checklist" relevant to the pre-operative phase may result in the cancellation of the operative procedure. A separate checklist "Cleaning Specifications" is for use by the contracted cleaning service company at IPSC.

## **PROCEDURE:**

The Operating Physician will:

- Order appropriate testing in sufficient time for completion prior to scheduled procedure
- Document "Informed Consent"
- Complete History and Physical Examination
- Mark the surgical site prior to entrance to the Operating Room

The Pre-Operative Registered Nurse will:

- Review, complete, sign and initial the "Safety Checklist" prior to releasing the patient for transfer to the Operating Room
- Ensure surgical site is marked per policy
- Patients with incomplete laboratory results or documentation must not be released to the Operating Room without an order from the Operating Physician to proceed without the ordered testing results and in compliance with Surgery Center policy
- The patient will not be released to the Operating Room without a completed History and Physical Assessment on the patient's chart

The Circulating Nurse will review the "Safety Checklist" prior to taking the patient to the Operating Room, and then complete the "Surgical Safety Checklist" while in the Operating Room.

The Post-Operative Nurse will complete the applicable part of the "Safety Checklist" prior to discharging the patient from the facility including, but not limited to:

- Completing the Post Procedural or PACU record
- Obtaining signature of discharging MD for anesthesia/post-surgical recovery
- Noting discharge time on record
- Copying any new prescriptions
- Providing physician phone number and follow-up instructions

## **INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)**

**Policy: Patient Safety Plan**

**Subject: Surgical Safety Checklists**

**Effective Date 01-12**

**Revised:03-12**

**Reviewed: 01/2016**

**Page 2 of 2**

---

- Name of responsible adult patient being discharged to

The “Cleaning Specifications” checklist is to ensure that contractors with IPSC who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.

- A representative of the contracted cleaning service employed by IPSC is responsible for filling out the checklist on a daily basis, with additions for actions performed weekly, monthly or quarterly.
- The staff of IPSC is responsible for maintaining a sanitary environment according to policies and procedures during the duration of the work day. The contracted cleaning service is responsible for cleaning at the end of each surgical day.

# **INNOVATIVE PROCEDURAL AND SURGICAL CENTER (IPSC)**

**Policy: Patient Safety Plan**

**Subject: Compliance with Surgical Safety Checklists**

**Effective Date 01-12**

**Reviewed: 01/2016**

**Page 1 of 1**

---

## **POLICY:**

The Patient Safety Officer and/or his or her designee(s) will periodically conduct quality improvement studies to monitor compliance with and effectiveness of patient safety checklists and policies.

## **PROCEDURE:**

1. Monitoring may include, but is not limited to, review of records, quality review reports, video monitoring, audits of sanitation supplies and patient questionnaires.
2. These quality improvement studies will be reviewed by the IPSC Safety Committee.
3. At least annually the patient safety checklists will be reviewed and revised as necessary to assure they reflect the most current standards in patient safety protocols. At this time the Committee will consider any additional checklists and/or policies that may be appropriate for adoption.
4. Summary of annual review, including development, revision and usage of patient safety checklists and policies will be reported to the Legislative Committee on Healthcare.

# INNOVATIVE PROCEDURAL AND SURGICAL CENTER

## SURGICAL SAFETY CHECKLIST

### BEFORE INDUCTION OF ANESTHESIA

### BEFORE SKIN INCISION

### BEFORE PATIENT LEAVES O.R.

With at least nurse and anesthetist)

**VERBALIZE OUT LOUD FOR ALL TEAM MEMBERS TO STOP AND  
VERIFY THE FOLLOWING:**

With nurse, anesthetist and surgeon)

<input type="checkbox"/> Ensure a clean and sanitary environment for each patient  <input type="checkbox"/> Patient identified per IPSC policy	<input type="checkbox"/> Confirm all team members have introduced themselves by name & role.	Nurse verbally confirms: <ul style="list-style-type: none"> <li><input type="checkbox"/> The name of the procedure</li> <li><input type="checkbox"/> Completion of instrument, sponge and needle counts    <input type="checkbox"/> N/A</li> <li><input type="checkbox"/> Specimen labeling (read specimen labels aloud, including patient name)    <input type="checkbox"/> N/A</li> <li><input type="checkbox"/> Whether there are any equipment problems to be addressed</li> </ul>
<input type="checkbox"/> Identification / Allergy band applied	<input type="checkbox"/> Correct patient and procedure <input type="checkbox"/> Correct position <input type="checkbox"/> Correct operative site & side <input type="checkbox"/> Surgical & Anesthesia consents are accurate & signed <input type="checkbox"/> Site has been marked by physician and is visible after prepping and draping.	<input type="checkbox"/> Intra-Op / Sterilization records completed and signed by RN  To surgeon, anesthetist and nurse: <input type="checkbox"/> Key concerns for recovery and management of this patient?
<input type="checkbox"/> Site marked <input type="checkbox"/> N/A	<input type="checkbox"/> Antibiotic prophylaxis been given within the last 60 minutes? <input type="checkbox"/> N/A	<div style="border-bottom: 1px solid black; width: 100%; margin-bottom: 10px;"></div> RN Signature/Initials
<input type="checkbox"/> Anesthesia machine and medication checks completed	<p style="text-align: center;"><i>Anticipated Critical Events</i></p> To surgeon: <ul style="list-style-type: none"> <li><input type="checkbox"/> Critical or non - routine steps?</li> <li><input type="checkbox"/> How long will the case take?    <input type="checkbox"/> N/A</li> <li><input type="checkbox"/> Anticipated blood loss?    <input type="checkbox"/> N/A</li> </ul> To anesthetist: <ul style="list-style-type: none"> <li><input type="checkbox"/> Any patient - specific concerns?</li> </ul> To nursing team: <ul style="list-style-type: none"> <li><input type="checkbox"/> Sterility (including indicator results) has been confirmed and logged on record.</li> <li><input type="checkbox"/> Required equipment &amp; implants (if needed) are in the room.</li> </ul>	
<input type="checkbox"/> Pulse oximeter/Blood pressure/ECG on and functioning.  <input type="checkbox"/> Oxygen applied <input type="checkbox"/> N/A	<input type="checkbox"/> Relevant images properly labeled and displayed? <input type="checkbox"/> N/A	
Difficult airway or aspiration risk? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Equipment/assistance available  <input type="checkbox"/> Pre-op labs/testing reviewed. <input type="checkbox"/> N/A		

Patient Label

Patient Label



9920 WEST CHEYENNE AVE. SUITE 120  
LAS VEGAS, NEVADA 89129  
(702) 998-7179

### Safety Checklist / Signature Verification

Note: Patient is patient himself/herself or legal representative	Pre-Op	PACU
1. Ensure a clean and sanitary environment for each patient		
2. Patient identified as per IPSC policy and ID/allergy band is applied		
3. Allergies and their adverse reactions verified and stated on the front of the chart		
4. Surgery/Procedure consent: Operative Procedure and site verified with patient		
a. Patient & RN witness signatures		
5. Anesthesia Consent:		
a. Patient & RN witness signatures		
b. Anesthesia provider signature (Anesthesiologist or MD performing the procedure)		
6. H & P completed and signed by MD		
7. Pre-Op MD orders:		
a. As ordered, pre-op tests: <input type="checkbox"/> Completed & results reviewed and placed in chart <input type="checkbox"/> Not present, note actions taken in nurses notes <input type="checkbox"/> N/A		
b. Standing orders to draw blood sugar and/or urine pregnancy test <input type="checkbox"/> N/A (Noted in appropriate logs & actions taken if out of range noted on pre-op record)		
c. Antibiotics as ordered: <input type="checkbox"/> Initiated <input type="checkbox"/> Completed <input type="checkbox"/> N/A		
8. Procedure site marked by MD		
9. Pre-Op Anesthesia form / Home Medication list / Pre-Op Record:		
a. Patient & RN signatures where applicable		
b. Medication list has dosage/frequency/date last taken. If patient doesn't know, document.		
10. Post-Op orders and Anesthesia orders noted and signed by RN		
11. Post procedural / PACU record completed and signed by RN		
12. Signature of discharging MD for anesthesia recovery & discharge time noted on Post procedural or PACU record.		
13. Discharge time to home or transfer to hospital noted		
14. Copy of any new prescriptions from IPSC <input type="checkbox"/> N/A		
15. Name of responsible adult patient is discharged to noted on discharge instructions		
16. Phone number of physician performing procedure/surgery on discharge instructions		

\* All areas must be signed off at the time of discharge for chart to be complete\*

RN Signature	Printed Name	Initials

## HENDERSON SURGERY CENTER

SUBJECT: AMBULATORY CARE SERVICES SAFETY	REFERENCE #7001
	PAGE: 1 OF: 3
DEPARTMENT: AMBULATORY CARE SERVICES	EFFECTIVE: 02/15/2010
APPROVED BY:	REVISED: 01/21/2011

### **POLICY:**

Henderson Surgery Center has established the following guidelines to ensure employee, patient and visitor safety while in the facility.

### **PROCEDURES:**

1. The Administrator is responsible for; maintaining safety standards, developing safety rules, supervising and/or training personnel in departmental standards. Reporting hazards
2. All employees are instructed to report defective equipment, unsafe conditions, acts or safety hazards immediately to their supervisor.
3. Keep electrical cords clear of passageways. Do not use electrical extension cords.
4. All equipment and supplies must be properly stored. All equipment shall be inspected by bio medical contractor prior to use.
5. Scissors, knives, pins, razor blades and other sharp instruments must be safely stored. Use of sharp spindles is prohibited.
6. All electrical machines with heat producing elements must be turned off when not in use.
7. Smoking is prohibited in the facility.
8. Do not permit rubbish to accumulate.
9. Notify the Administrator immediately of improper illumination and ventilation.
10. Furniture and equipment must be arranged to allow passage and access to exit's at all times.
11. Minor spills, such as water, will be cleaned immediately by the employee who discovers the spill. Major spills will be cleaned by available personnel.
12. Report faulty equipment to the Administrator or vendor as per policy.
13. Obey all warning signs.
14. File drawers and cabinet doors shall be closed when not in use.
15. Wear suitable clothing.



SUBJECT: AMBULATORY CARE SERVICES SAFETY	REFERENCE #7001
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE: 2 OF: 3
	EFFECTIVE: 02/15/2010
APPROVED BY:	REVISED: 01/21/2011

16. Cotton scrub suits are to be used.
17. Temperature of the procedural rooms shall be maintained between 69 to 72 degrees F.
18. When a physician wishes to use his/her personal electrical equipment, it shall first be inspected carefully for defects.
19. Woolen and synthetic blankets shall not be permitted in surgery or recovery room.
20. A patient will be attended by an anesthesiologist until the patient is transported to post anesthesia care unit. If no anesthesiologist is involved in the care of the patient, the Endoscopist shall perform those duties in the PACU for which an anesthesiologist would normally have been responsible.
21. All equipment must be grounded to maintain a constant path to floor.
22. Only 3-prong plugs are to be used
23. Wheels on gurneys must be locked except during transport.
24. Defibrillators shall be used only when staff members are standing on dry floor and no part of their body is in contact with the patient's bed or the patient receiving the cardioversion.
25. To reduce possible shock, use all electrical equipment per manufacturer's instructions and always with dry hands.
26. Uninsulated invasive catheters are prohibited.
27. No modification of equipment is authorized, except as specified in the manufacturer's recommendations and will be done only with the explicit approval of the Administrator.
28. No equipment will be placed into use until a written verification of proper operation, per manufacturer's standards, has been made by the Biomed Company. Equipment which has been subjected to temporary repair (taping, wiring, etc.) will NOT be placed in use.
29. Discard needles, clippers, scalpels and broken glass only into approved sharps containers.
30. Gurney side rails will be kept in the UP position whenever patients are on gurneys.
31. Understand and practice good body mechanics.

SUBJECT:     AMBULATORY CARE SERVICES SAFETY	REFERENCE #7001
DEPARTMENT: AMBULATORY CARE SERVICES	PAGE: 3 OF: 3
APPROVED BY:	EFFECTIVE: 02/15/2010
	REVISED: 01/21/2011

32. Do not leave equipment standing in traffic lanes. Return equipment to its proper location when not in use.
33. Do not obstruct fire equipment. Know location of firefighting equipment and how to use it. Know evacuation routes and what to do in case of fire.

# Great Basin Surgical Center

**SUBJECT: Patient Safety Improvement and Management**

**Program: Patient Safety Plan**

**Policy # CQIP.10**

**APPROVED: January 2015**

---

## I. Overview and Purpose

Attention to maintaining and improving **patient safety** and well being is inherent in the facility's 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, **Great Basin Surgical Center** must fully understand the processes and systems that are utilized by the organization to deliver patient care. From this deeper understanding, Great Basin Surgical Center 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 this facility's commitment to the community it serves;
- enable **Great Basin Surgical Center** and individuals who work and practice at this facility to respond appropriately to **adverse events**, proactively identify risk-reduction strategies, and participate in process and system redesign to reduce risk of patient harm;
- allow this facility 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 and
- Begin the healing process for those individuals suffering from medical accidents.

The **Great Basin Surgical Center's** leadership, medical staff, and employees must actively embrace and support the patient safety improvement and management program in order to achieve the results outlined above. The purpose of the patient safety plan is to provide a framework for the implementation of various components of the patient safety program.

## II. Principles

Great Basin Surgical Center's patient safety plan is based on the following principles.

- Improvement in **patient safety** will not occur unless there is a commitment by the facility governing body and senior management and an overt, clearly defined, and ongoing effort on the part of the Facility leaders, physicians, managers, and employees to sustain the organization's interest and focus on **patient safety**. The leadership staff will keep the facility board of managers apprised of any adverse outcomes, safety problems, and efforts directed at improving **patient safety**.
- Communication about the importance of **patient safety** must be well conceived, repeated, and consistent across the entire organization. In its communication with physicians, employees, and patients, **Great Basin Surgical Center** will stress that safety problems are quality problems and that all persons must be involved in the **patient safety** reporting system, identifying deficiencies in current care processes, and in designing and executing solutions needed to create safer systems. All individual concerns and ideas about how to improve **patient safety** will be valued and respected.

## Great Basin Surgical Center

**SUBJECT: Patient Safety Improvement and Management**

**Program: Patient Safety Plan**

**Policy # CQIP.10**

**APPROVED: January 2015**

---

- Responsibility and accountability for **patient safety** must be clearly articulated to physicians, managers, and employees. **Great Basin Surgical Center** will incorporate **patient safety** accountability into position descriptions, orientation, and ongoing education and training.
- Feedback about how the sharing of information and reporting of various types of events was acted upon and used to make improvements in the care delivery system is important. **Great Basin Surgical Center** will provide feedback to those employees and health care providers who have reported or disclosed **errors**. This feedback may range from acknowledgement that the report has been received to results of detailed root cause analyses.
- Punitive approaches toward individuals involved in various events pushes reporting and disclosure underground, thereby preventing an opportunity for the organization to appropriately intervene to correct the underlying problems. This organization is committed to developing ways to reward rather than discourage reporting of **errors** or **patient safety** concerns and will celebrate successes at improving the reporting of **patient safety** concerns and **errors** and how such information has been used to make improvements in facility processes, systems, and care delivery.
- Abundant evidence in human factors and cognitive psychology literature recognizes that most human **errors** are symptoms of underlying system failures, not personal failures. When human failures do occur, they are most often consequences of inevitable, “built-in” limitations of human cognition or endurance. Individuals involved in **incidents** and **serious events** will not be blamed for the occurrence or subjected to retribution. Rather, **Great Basin Surgical Center** will offer support and counseling to individuals involved in an event with an unanticipated outcome and involve these individuals in assisting the organization to learn from the event and develop strategies to avoid the possibility of having such an event occur again. At **Great Basin Surgical Center** employee accountability may include any or all of the following: acknowledging the risks involved with complex healthcare delivery; acknowledging that an error occurred with possible resultant injury; providing remedial or restorative care; assisting in possible **root cause analysis** of the processes involved; and cooperating in fixing the problem(s) in the processes.
- **Great Basin Surgical Center** will ensure that processes, functions and services are designed with a focus on **patient safety**. This will be accomplished by using available information from within and external to the organization to design or redesign processes to minimize risk to patients. To the extent possible, the Facility will analyze or pilot test the new design or redesign to ensure that no new risks have been embedded into the new or redesigned process prior to its implementation.
- **Great Basin Surgical Center** will seek to reduce variation in how patients are cared for in the organization and will devise strategies to avoid reliance on memory through the use of standardized protocols, checklists, work processes and use of technology/automation.
- Patients who are able are encouraged to actively participate in care decisions. Those who are informed of their treatment plan and properly educated and coached to question something that doesn't seem right can often prevent an **error** from occurring. **Great Basin Surgical Center** will include patients as active participants in their care and promote patient and family questioning of

## Great Basin Surgical Center

**SUBJECT: Patient Safety Improvement and Management**

**Program: Patient Safety Plan**

**Policy # CQIP.10**

**APPROVED: January 2015**

---

the organization's routine, procedures, and processes whenever something does not "look" or "feel" right.

- As the field of **patient safety** evolves, the effectiveness of various approaches to improving **patient safety** will be studied and evaluated. The Facility will consult the literature, examine the experiences of others who have responded to similar issues, and consider recommendations made by various authoritative groups in developing alternatives to reduce the possibility of error or having the error reach the patient.
- The facility will adopt patient safety checklists for use by providers of health care in the facility. These checklists will be designed to ensure that providers of health care in the facility follow recognized protocol to improve the health outcomes of patients at the facility.
- Patient safety checklists will include, but not be limited to:
  1. Checklist for appropriately identifying a patient and ensuring that the patient is being provided treatment ordered by a provider of health care, including, without limitation requiring providers of health care positively to identify the patient upon each interaction.
  2. Checklist for ensuring that each provider of healthcare adheres to the universal precautions protocol, including, without limitation, requiring a provider of health care to wash his/her hands before and after every interaction with a patient and after coming into direct contact with a surface or object which may be contaminated.
- These checklists will be reviewed annually by the Patient Safety Committee.

### III. Key Definitions

- **Error** – The failure of a planned action to be completed as intended (i.e., error of execution) or the use of an incorrect plan to achieve an aim (i.e., error of planning). [Institute of Medicine Report, *To Err is Human: Building a Safer Health Care System*] or

An unintended act, either of omission or commission, or an act that does not achieve its intended outcome. [Joint Commission on Accreditation of Healthcare Organizations]

- **Adverse Event** – An injury caused by medical management rather than the underlying condition of the patient. An **adverse event** attributable to **error** is a "preventable **adverse event**." [Institute of Medicine Report, *To Err is Human: Building a Safer Health Care System*]. Further definitions include:
  1. 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.
  2. Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.

## Great Basin Surgical Center

**SUBJECT: Patient Safety Improvement and Management**

**Program: Patient Safety Plan**

**Policy # CQIP.10**

**APPROVED: January 2015**

---

3. Events such as actual breaches in medical care, administrative procedures, or other events resulting in an outcome that is not associated with the provision of care and service for the patient.
4. All events involving reactions to drugs and materials.
5. Circumstances or events that could have resulted in an adverse event (near-miss events).

***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. Surgery performed on the wrong patient or wrong body part. [Joint Commission on Accreditation of Healthcare Organizations]

***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. [Joint Commission on Accreditation of Healthcare Organizations]

***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**. 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. [Joint Commission on Accreditation of Healthcare Organizations]

***Failure Mode Effects and Criticality Analysis*** – A proactive approach to assessing the intended and actual implementation of a process to identify steps in the process where there is, or may be, undesirable variation or failure modes; the possible effect on patients for each identified failure mode; and how serious or critical the possible effect could be on the patient. For the most critical effects, a **root cause analysis** is conducted to determine why the variation leading to that effect may occur in order to better design the process or system to minimize the risk of that failure mode or protect patients from the effects of that failure mode. [Joint Commission on Accreditation of Healthcare Organizations]

***Action Plan*** – the product of **root cause analysis** that identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future. The plan addresses 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]

***Patient Safety*** – Freedom from accidental injury while receiving health care services.

## Great Basin Surgical Center

**SUBJECT: Patient Safety Improvement and Management**

**Program: Patient Safety Plan**

**Policy # CQIP.10**

**APPROVED: January 2015**

---

### **Scope and Components of the Patient Safety Program**

#### **The Patient safety plan shall:**

- Designate a Patient Safety Officer
- Establish a Patient Safety Committee
- Establish a system for the healthcare workers of a medical facility to report serious events and incidents.
- Prohibit any retaliatory action against a health care worker for reporting a serious event or incident.

#### **Reporting and notification**

##### **Reporting**

- A healthcare worker who reasonably believes that a serious event or incident has occurred shall report the serious event or incident according to the patient safety plan. The report shall be made immediately or as soon thereafter as reasonably practicable, but in no event later than 24 hours after the occurrence or discovery of a serious event or incident.
- **Internal Reporting:** In order to have an effective **patient safety** improvement and management program, there must be an emphasis on reporting all types of events that may harm or have harmed patients. The Facility has adopted a non-punitive approach in its management of **adverse events** and reporting. All members of the medical staff and employees are required to report suspected and/or identified medical **errors** and should do so without the fear of reprisal in relationship to their employment. The Facility focuses first and foremost on system/process improvements and will not blame the individual(s) involved in the event or seek retribution against the individual for reporting the event.
- However, in the event that a member of the medical staff or employee participates in willful or malicious misconduct, sabotage, substance abuse, criminal activity, fails to report the event truthfully or in a timely fashion, or makes an egregious **error** demonstrating a lack of fundamental knowledge necessary to carry out his/her job responsibilities, **Great Basin Surgical Center** will, as appropriate, institute disciplinary or corrective action.
- **External Reporting:** **Serious events** or **incidents** will be reported to the appropriate authorities, utilizing the required reporting format.

#### **Patient Safety Officer**

##### **The patient safety officer of the facility shall perform the following:**

- Coordinate and serve on the Patient Safety Committee that meets monthly
- Ensure the investigation of all reports of serious events and incidents

## Great Basin Surgical Center

**SUBJECT: Patient Safety Improvement and Management**

**Program: Patient Safety Plan**

**Policy # CQIP.10**

**APPROVED: January 2015**

---

- Take such action as is immediately necessary to ensure patient safety as a result of any investigation
- Report to the Patient Safety Committee regarding any action taken to promote patient safety as a result of investigations.
- Conduct periodic facility wide patient safety rounds
- Evaluates the effectiveness of the patient safety checklists utilized at the facility.
- Provides education and training to facility staff related to patient safety
- Assists in the analysis of data to evaluate the effectiveness of the Patient Safety Plan
- Prepares for and participates in Root cause Analysis of sentinel events
- Implements immediate proactive action for patients, visitors or staff that may be affected by an adverse event
- Identifies opportunities for sharing appropriate information within the organization to demonstrate the impact of the **patient safety** program to medical staff, employees, and board of managers;
- Reviews and acts on recommendations issued by the Joint Commission on Accreditation for Healthcare Organizations, AAAHC, the National Quality Forum, the Food and Drug Administration, the Centers for Disease Control and Prevention, The Nevada Department of Health, the Institute for Safe Medication Practices, the Occupational Safety and Health Administration, the Agency for Healthcare Research and Quality and other groups as appropriate;
- Researches and implements best practice ideas gained from networking and literature reviews;
- Recommends **patient safety** education and training opportunities for medical staff and employees based on information developed in the committee and may include case studies, communication skill development, and team training;
- Coordinates all **patient safety** activities across the organization;
- Develops an annual evaluation process with medical staff and employees to assess progress in developing a culture of safety in the organization;

### **Patient Safety Committee**

- The patient safety committee shall be composed of the facilities patient safety officer and
- Three providers of health care who treat patients at the facility including, without limitation:
  - A Physician
  - A Member of Nursing Service
  - The Pharmacy Consultant
- One member of the governing board.
- The committee shall meet monthly.

### **The patient safety committee shall perform the following:**

- Receive reports from the patient safety officer pursuant to NRS 439.870.



## Great Basin Surgical Center

**SUBJECT: Patient Safety Improvement and Management**

**Program: Patient Safety Plan**

**Policy # CQIP.10**

**APPROVED: January 2015**

---

- Evaluate investigations and actions of the patient safety officer on all reports of sentinel events alleged to have occurred at the facility
- Review and evaluate the quality of patient safety measures carried out by the facility to improve the safety of patients who receive treatment at the facility.
- Make recommendations to the governing body of the facility to reduce the number and severity of sentinel events that occur at the facility
- Report to the governing body of the facility on a quarterly basis regarding the number of sentinel events that occurred at the facility during the previous quarter, and its recommendations to eliminate future serious events and incidents.
- Adopt, evaluate, and revise patient safety checklists utilized at the facility
- On or before July 1, provide a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Healthcare
- The Patient Safety Committee will revise adopted checklists, or consider additional safety checklists that may be appropriate for adoption for use at the facility.
- Adopted checklists will be evaluated by the Patient Safety Committee as necessary to ensure that the checklist reflects the most current standards in patient safety protocols.
- The Facility Patient Safety Committee will report to the Legislative Committee on Health Care annually, on or before July 1 of each year. The annual report will include information regarding the development, revision, and usage of the patient safety checklists and a summary of the annual review conducted by the Patient Safety Committee of any additional checklists adopted by the Facility.

### **Confidentiality and compliance**

- Any document, materials or information solely prepared or created for compliance with the patient safety program are considered confidential and shall not be discoverable or admissible as evidence in any civil or administrative action or proceeding.
- Any documents, materials, records or information that would otherwise be available from original sources shall not be construed as immune from discovery or use in any civil or administrative action or proceeding merely because they were presented to the patient safety committee or governing body of the facility.

### **Meetings**

- No person who performs responsibilities for or participates in meetings of the patient safety committee or governing body of the facility shall be allowed to testify as to any matters **within** the knowledge gained by the person's responsibilities or participation on the patient safety committee or governing body of the facility provided, however
- The person shall be allowed to testify as to any matters within the person's knowledge which was gained **outside** of the person's responsibilities or participation on the patient safety committee or governing body of the facility

- **Patient Safety Committee**

## Great Basin Surgical Center

**SUBJECT: Patient Safety Improvement and Management**

**Program: Patient Safety Plan**

**Policy # CQIP.10**

**APPROVED: January 2015**

---

**Leadership and Continuous Improvement:** The leadership of Great Basin Surgical Center supports a systematic, coordinated, and continuous approach to the improvement and management of **patient safety**. This will be achieved through the establishment of policies, procedures, protocols and checklists to support effective responses to actual **adverse events**; ongoing proactive risk reduction activities to minimize the occurrence of **errors** or the probability that those **errors** will reach the patient; involvement of the medical staff, employees, and patients/families; and designing or redesigning processes and systems on the basis of what has been learned internally and externally through **patient safety** initiatives.

**Retrospective Analysis:** The following types of events may be addressed by the **patient safety** program.

- **Near-Miss and Actual Medication Errors** (wrong dose, wrong route, missed dose, wrong drug, wrong patient, wrong administration time)
- **Adverse Drug Events** (defined as patient harm related to medication use).
- **No Harm Near Miss Events or Incidents**
- **Adverse Clinical Events** (missed diagnosis, body fluid exposure, wrong surgery site, infection, , communication error)
- **Sentinel Events**
- **Selected Administrative Incidents** (patient identification, discharge problems, documentation, informed consent issues)
- **Other Situations or Incidents** (other situations which may involve infrastructure/environmental issues, work design, patient care products or equipment)
- **Evaluation of patient safety checklists**
- **Authority and Responsibility**

**Board of Managers** – The overall authority for direction of the **patient safety** plan rests with Great Basin Surgical Center’s Board of Managers. The Board of Managers oversees the implementation and maintenance of the various components of the **patient safety** plan.

The Administrator, Medical Director, Anesthesia Director and Director of Nursing in collaboration with administrative, managerial and clinical staff ensures that the **patient safety** plan is implemented throughout the organization and integrated appropriately with other activities within the organization which contribute to the maintenance and improvement of **patient safety**, such as performance improvement, environmental safety, and risk management. The Board, Administrator and DON shall designate a qualified individual in the organization to be the Patient Safety Officer and manage the **patient safety** plan.

**Management Staff** – Great Basin Surgical Center management will ensure that the patient safety plan and program will be given high priority and will support the program. Management will:

## Great Basin Surgical Center

**SUBJECT: Patient Safety Improvement and Management**

**Program: Patient Safety Plan**

**Policy # CQIP.10**

**APPROVED: January 2015**

---

- assure allocation of adequate resources for organizational and departmental **patient safety** initiatives;
- assign staff to participate in risk reduction activities;
- ensure that sufficient time is available for staff participation in **patient safety** activities at both the department and organizational level;
- reinforce reporting expectations and management of **adverse event** resulting from an **error** that has reached the patient resulting in harm;
- establish a non-punitive culture that encourages reporting;
- make sure that staff attend all required **patient safety** education programs;
- supplement mandatory education programs with other **patient safety** education and training that relates directly to the jobs performed by employees in that area of the organization; and
- Ensure safe practice by all staff through observation and use of other appropriate evaluative processes.

**Medical Staff**— Members of the medical staff are responsible for actively participating in the patient safety improvement. An active participant will:

- assume responsibility for identifying processes or systems that could potentially lead to **errors** and **adverse events**;
- know and follow organizational and departmental policies and procedures applicable to assigned duties;
- avoid taking shortcuts or encouraging others in the organization to shortcut established policies and procedures as a means of facilitating patient care;
- inform patients and families about care, medications, treatments, and procedures, encourage them to ask questions, and participate with caregivers in the development of their treatment plan;
- use sound judgment and awareness of potential hazards before taking action;
- participate in required organizational and departmental **patient safety** education programs and other activities designed to improve departmental and organizational **patient safety**;
- promptly report **serious events** and **incidents** in accordance with established facility policy and procedure; and
- Assume responsibility for one's own professional development and education to improve individual performance and promote **patient safety**.
- Utilize the patient safety checklists adopted by the facility's Patient Safety Committee

**Facility Staff** – Employees are responsible for actively participating in the facility's patient safety improvement and management program. An active participant will:

- assume responsibility for identifying processes or systems that could potentially lead to **errors** and **adverse events**;
- know and follow organizational and departmental policies and procedures applicable to assigned duties;
- avoid taking shortcuts or encouraging others in the organization to shortcut established policies and procedures as a means of facilitating patient care;
- inform patients and families about care, medications, treatments, and procedures, encourage them to ask questions, and participate with caregivers in the development of their treatment plan;

## Great Basin Surgical Center

**SUBJECT: Patient Safety Improvement and Management**

**Program: Patient Safety Plan**

**Policy # CQIP.10**

**APPROVED: January 2015**

---

- use sound judgment and awareness of potential hazards before taking action;
- participate in required organizational and departmental **patient safety** education programs and other activities designed to improve departmental and organizational **patient safety**;
- promptly report **serious events** and **incidents** in accordance with established facility policy and procedure; and
- Assume responsibility for one's own professional development and education to improve individual performance and promote **patient safety**.
- Utilize patient safety checklists that have been adopted by the Patient Safety Committee

**Medical Staff and Employee Education:** During the employee orientation process, education will be provided related to **patient safety**. Similar education will be provided for new physicians at the time of appointment. This education will focus on the facility **patient safety** plan, policies and procedures particularly as they relate to reporting, confidentiality. These responsibilities will be reinforced with employees through the annual mandatory education program and with physicians during their reappointment process and be documented as part of the periodic performance evaluation. When individual employees and physicians serve on teams involved in **root cause analysis** and failure mode and effect analysis, additional training will be provided on tools used in the analysis process.

**Facility patients and Families** – Great Basin Surgical Center recognizes that patients and their families play a critical role in ensuring **patient safety**. In particular, the patient and family can often serve as the final checkpoint to avoid an **error** and adverse outcome. As such, Great Basin Surgical Center will provide appropriate education to patients and families to make sure patients and families:

- Disclose relevant medical and health information to caregivers to facilitate appropriate care delivery;
- Report unexpected changes in a patient's condition or perceived risks to the patient's health and well being to responsible caregivers;
- Question any variation in medications, treatment, or plan of care from what the patient or family was informed to expect; and
- Encourage completion of any specific questionnaires related to satisfaction, quality or **patient safety**.

## VII. Management of Events and Reporting

### Immediate Management of Event

Upon identification of an error, incident, or event, the patient care provider should:

- Take appropriate steps to care for the patient and minimize negative outcomes;
- Contact the patient's attending physician and other physicians as appropriate to report the **error, incident**, or event and implement any additional therapy or treatment as ordered by the physician;
- As appropriate, implement steps to contain the risk to others as in possibly a drug or medical device recall;
- Preserve any information or evidence that may be helpful in analyzing the **error, incident**, or event. This includes physical evidence such as preservation of IV tubing, fluid bags, equipment such as pumps, the unit of blood, or medication labels;

## Great Basin Surgical Center

**SUBJECT: Patient Safety Improvement and Management**

**Program: Patient Safety Plan**

**Policy # CQIP.10**

**APPROVED: January 2015**

---

- Report the **error, incident**, or event immediately to the staff member(s) immediate supervisor;
- Complete the required variance report form according to Facility policy and procedure; and
- Obtain appropriate support for staff members involved in the error, incident, or event as needed.

### **Internal Reporting**

**Serious events, incidents** and **infrastructure failures** are to be reported by involved personnel to the Director of Nursing, ADM or Patient Safety Officer.

- During normal operating hours, notification must be given to on-site management both verbally and in writing. **Serious events** must also be reported to the Patient Safety Officer and/or the DON or ADM who will notify the Medical Director. The incident shall be reported by the involved personnel or on-site management.
- All notifications received will be reviewed by the Patient Safety Officer as soon as possible following the occurrence or discovery. The Patient Safety Officer in conjunction with clinical and administrative leadership will determine if external reporting is required.
- At the direction of the DON and/or Patient Safety Officer or designee, additional information on **serious events** or **incidents** will be collected and appropriate actions taken
- At the monthly Patient Safety Committee meeting, all **serious events** will be individually reviewed and data on **incidents** will be discussed.
- Minutes from the Patient Safety Committee will be forwarded to the Continuous Quality Improvement Committee or designated sub-committee and the Board of Managers.

### **VIII. Program Review**

In addition to quarterly reports to the Great Basin Surgical Centers Board of Managers about the Facility's patient safety program and patient safety checklists, the DON or Patient Safety Officer will present an annual report to the Board of Managers about the occurrence of **sentinel events, serious events**, and **incidents**; medical staff, employee, and patient family education and involvement; proactive hazard analysis; actions taken to improve **patient safety**, and other key information related to **patient safety**. Together with the committee, the DON and Patient Safety Officer will review and update the organization's **patient safety** plan on a yearly basis.

# **QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN**

## **FLAMINGO SURGERY CENTER 2016**

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**, community, and regulatory standards for ambulatory surgical care, this plan allows for a planned, systematic, organization-wide approach to the quality improvement process, reducing risks through an effective risk management plan and 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 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;
- Reducing medical/health 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 **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 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 Process
- Quality Studies
- Risk Management Strategies
- Patient Safety
- Infection Control Strategies
- Medication Safety
- Radiation Safety

### **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.

In early 2016, Flamingo 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. 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 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, 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, 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 (□ HO) □ An injury or 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 (□ HO) □

**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 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 side, 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:** 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).

**Root Cause Analysis (RCA):** A method of problem solving that tries to identify the root causes of faults or problems. RCA practice tries to solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing 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 root cause analysis. RCA is typically used as a reactive method of identifying event(s) causes, revealing problems and solving them. The RCA findings are reported at the quality meetings, MEC and GB meetings. In 2016, the ASD will be moved toward an online program for analysis of serious events called Serious Event Analysis (SEA).

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/health 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 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 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 and families, 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 and creating a safe environment.

### **Peer Review**

Ambulatory Surgery Centers are required by AAAHC, CMS, and other regulatory agencies to conduct quality improvement and peer review. Peer review activities include ongoing random review, specialty specific review and review of 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. The **FLAMINGO 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 to:

- Assure QI/Risk/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 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 2016, upon approval from the MEC and Governing Body:

Quality Improvement Committee Chair	Names have been removed based on
Risk Manager	NRS 439.843.
Infection Control	
Patient Safety Committee Chair	

#### 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 (10 days for state of NV) 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 FLAMINGO 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 for 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
  - "Near miss" event
  - 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 include at a minimum:
  - 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 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 b 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
- 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

### **Intra-op Care and Processes**

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

### **Complications**

- Unexpected complications
- 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

**Resuscitation**

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

**Diagnostics Results**

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

**Medication Management**

- Utilize “One source” truth for allergy 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**

- 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
- Appropriate endoscopy re-processing if applicable
- 24/7 Monitoring of temperature and humidity of designated rooms

**Provision of Care/ Medical Record Review**

- 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.
- 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

**Safety**

- Surveillance rounds and corrective follow up on deficiencies

- Process for notifying and following through on recalls
- Fire drills
- Emergency preparedness drills
- Infant/child abduction drill
- Sharps prevention program
- Active Shooter drill

### **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

### **SUMMARY OF QUALITY GOALS**

The 2015 Risk Reduction Program was completed with deadlines met

The Medical Director had not started at the time of the Medical Director's Conference

We continue to monitor expired meds and supplies

Due to management changes, we only completed about half of staff led in services on a monthly basis.

### **QI/RIS GOALS for 2016**

**2016 Clinical Agenda – see attached power point slides**

#### **2016 Division Goals**

- To continue to reduce the number of sharp occurrences (In 2014 the Division reported 20 occurrences and in 2015 the Division reported 17 sharp occurrences.)
- To continue to reduce the number of falls. (In 2014 there were 25 falls reported within the Division and in 2015 with the implementation of the falls toolkit, the falls reported rate decreased to 14 reported falls in 2015.)
- To complete the 2016 Risk Reduction Program initiatives.
- To meet the 2016 ASD Clinical Objectives.

## **CENTER SPECIFIC QALITY GOALS**

- Completion of 2016 Risk Reduction Program and meet all deliverable dates.
- To continue to market for new physicians.
- To get staff comfortable in their new roles at FSC.
- To promote continuing education
- To continue to have a 0 infection rate
- To promote cross training between pre op and pacu.



## **EYE SURGERY CENTER OF NORTHERN NEVADA**

Policy and Procedure

Section 8-1

Subject: QUALITY IMPROVEMENT RISK MANAGEMENT PLAN

Review: Annually

Effective Date: 07/01/07

Date of Revision: 05/12/08

### **Policy Statement:**

ESCNN maintains an active, integrated, organized, peer-based continuous quality improvement program. The ASC utilizes a systematic approach for Performance Improvement through multidisciplinary cooperation. Quality Improvement activities demonstrate the systematic, “closing the loop” process. This process incorporates an improvement model that includes design, identification of problems/concerns in the care of patients; (evaluation) of the identification of problems/concerns; (resolution measures); re-evaluation; reporting. The plan will address clinical, administrative, cost-of-care issues and patient outcomes. The focus will be activities that affect the majority of patients serviced and consider high-risk, high-volume, and problem-prone patients. The following plan is an integral part of the ASC’s overall goal of continually improving organizational performance and patient health outcomes.

### **Objectives:**

The Quality Improvement activities must be designed to evaluate several parameters of quality. Continuous quality improvement, when properly performed, should meet a few main objectives:

1. Prompt attention to high-priority access of clinical care.
2. An increased likelihood of desired health outcomes through the facility’s participation in performance measurement and quality improvement activities.
3. Stimulate analysis of the appropriateness and effectiveness of clinical care.
4. Findings of QI activities are incorporated into the organization’s educational process.
5. Mechanisms are in place for designing, measuring, assessing, improving, and redesigning organizational functions-knowing that performance can be improved when high standards appear to be met.
6. Leaders of the organization are held accountable for setting priorities and providing needed resources to achieve the highest quality of care possible.

## **EYE SURGERY CENTER OF NORTHERN NEVADA**

7. Patient and organizational focused functions are maintained in the process.
8. Dimension of performance aspects are considered:
  - A. Efficiency
  - B. Availability
  - C. Timeliness
  - D. Efficacy safety
  - E. Respect and caring
  - F. Continuity
9. Consideration is given to needs of patients, surgeons, vendors, payors, and staff in the process.
10. A Surveillance Plan for the prevention of infections and communicable disease for patients and staff.
11. Design improvement functions which affect the majority of patients serviced and consider high-risk, high-volume and problem-prone patients.
12. Tracking surgical procedures that result in unplanned patient admission to a hospital within 72 hours of a procedure due to post-op complication.
13. Consideration is given to the mission, philosophy, and scope of service of the ASC organization.
14. Results of peer review information are used as part of the basis for granting continuation of privileges.
15. The implementation of a consistent process for the identification, reporting, analysis, and prevention of adverse incidents/occurrences.

### **Process:**

1. The Center utilizes the systematic “closing the QI loop” process to promote continuous quality improvement throughout the facility.
2. This process provides for a planned, systematic, organization-wide, prioritized, approach that is inter-disciplinary and uniform.

## **EYE SURGERY CENTER OF NORTHERN NEVADA**

3. QI activities conducted by specific clinical disciplines within the organization are consistent with the characteristics of the overall CQI program.
4. The improvement activities are on-going and part of the Center's planning process.
5. The improvement activities take into consideration patient, surgeon, and staff needs and expectations as well as others; i.e. payers, community.
6. The improvement activities take into consideration patient and organizational functions as well as dimensions of performance.
7. Improvement activities consider:
  - A. Scope of service
  - B. Mission and philosophy
  - C. Important aspects of care
  - D. High-volume, high-risk, problem-prone patients
  - E. Contracted services, if appropriate
  - F. Patient, surgeon, staff satisfaction
  - G. Incident reports
  - H. Standards of practice
  - I. Identifying unacceptable or unexpected trends that influence patient outcomes
8. Improvement activities are re-designed as appropriate.
9. Individual performance is addressed as necessary and appropriate.

### **Characteristics:**

Quality improvement activities have the following characteristics:

1. Important problems or concerns in the care of patients are identified. Sources of identifiable problems include, but are not limited to:
  - A. Unacceptable or unexpected results of on-going monitoring of care, such as complications, hospital transfers, malpractice cases, lack of follow-up on abnormal tests results, prescribing errors for medications, specific diagnoses, and so forth
  - B. The clinical performance and practice patterns of health care practitioners

## **EYE SURGERY CENTER OF NORTHERN NEVADA**

- C. Medical record review for quality of care and completeness of entries
  - D. Quality controls for and use pharmaceutical services
  - E. Other professional and technical services provided
  - F. Assessment of patient satisfaction
  - G. Direct observation
  - H. Staff concerns
  - I. Accessibility
  - J. Medical/legal issues
  - K. Wasteful practices
  - L. Over-utilization and under-utilization
2. The frequency, severity, and source of suspected problems or concerns are evaluated. Healthcare practitioners participate in the evaluation of identified problems or concerns.
  3. Measures are implemented to resolve important problems or concerns that have been identified. Healthcare practitioners, as well as administrative staff, participate in the resolution of the problems or concerns that are identified.
  4. The problems or concerns are re-evaluated to determine objectively whether the corrective measures have achieved and sustained the desired result. If the problem remains, alternative corrective actions are taken as needed to achieve and sustain improvement.
  5. Through the organization's designated mechanisms, quality improvement activities are reported, as appropriate, to the proper personnel, the administrator, and the governing body.
  6. The facility has a process in place to review key indicators in comparison with other similar organizations.
  7. Benchmarks used will be based on state, local, or national standards. Participation in performance benchmarking activities will allow for the comparison of key performance measures with other similar organizations or with recognized best practices of national or professional targets or goals. These activities may include:
    - A. Selected performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients served
    - B. Systematically collecting and analyzing data related to the selected performance measures
    - C. Ensuring the validity and reliability of data

## **EYE SURGERY CENTER OF NORTHERN NEVADA**

- D. Measuring changes in performance related to the performance measures
- E. Demonstrating and sustaining performance improvement over time
- F. Using benchmarks that are based on local, state, or national standards, i.e. performance measures

The results of benchmarking activities are incorporated into other quality improvement activities of the ASC and reported to the governing body and throughout the organization.

### **Quality Committee:**

OUTLINE OF DEFINED RESPONSIBILITIES: The Governing Body of the Center will retain overall responsibility for the design, implementation and evaluation of the Plan. It is anticipated that the Governing Body will delegate direct responsibility for development and implementation of the Plan to the Clinical Director and/or Administrator of the Center.

1. Further, the Governing Body shall cause to be created a Quality Improvement/Risk Management Committee (Committee) that will consist of the following individuals:
  - A. The Medical Director of ESCNN, who shall serve as the committee chairperson
  - B. The Clinical Director of the Center
  - C. The Administrator of Eye Surgery Center of Northern Nevada, and
  - D. The designated Risk Administrator, who may be one of the individuals delineated above
2. The Committee will report administratively to the President of the Center. Individual members of the Committee will oversee QI/RM activities within the purview of their existing administrative responsibilities and may delegate specific aspects of the Plan implementation to other employees of ESCNN, as appropriate.
3. It will be the responsibility of the Committee to conduct, at least quarterly, a comprehensive assessment of risks and quality improvement issues that might affect the life and/or welfare of the Center patients or employees, the quality of care delivered by the Center, and the effectiveness and efficiency with which the Center utilizes and safeguards its facilities and services. In order to provide independent review, a second physician will participate in QI activities relating to each physician employee of the Center. Outside physicians may be contracted on an as needed basis to provide this service.

## **EYE SURGERY CENTER OF NORTHERN NEVADA**

4. This review should specifically address the objectives defined in section 1 above, as well as the impact of peer-review and patient satisfaction surveying on the QI/RM process. A result of this review should be the updating and reissuing of this Plan and submittal of the revised Plan to and the approval thereof by the Governing Body of the Center.
5. The purpose of the committee is to monitor important aspects of care and to encourage communication about the ASC operations which will provide maximum opportunities to implement continuous quality improvement and to aid in quality assurance. The following will be reviewed at each meeting:
  - A. All incident/occurrence reports related to patient and employee safety
  - B. All patient evaluation cards and surveys
  - C. All direct hospital admissions and transfers
  - D. All complication data generated by chart review
  - E. Medical chart audit studies (at least one per quarter)
6. A permanent record will be kept of each meeting.
7. Important patient care problems or concerns are identified. These problems or concerns may arise from clinical, administrative, or cost-of-care issues, as well as actual or potential problems affecting patient outcomes.
8. The frequency, severity, and source of suspected problems or concerns are evaluated.
9. Effective measures are developed and implemented by appropriate personnel to resolve important problems or concerns that have been identified.
10. Problems or concerns are re-evaluated to determine objectively whether the corrective measures have achieved and sustained the desired result. If not, alternative corrective measures are developed and implemented as needed to resolve the problem or concern.
11. Quality improvement and risk management activities and the results thereof, are reported to the Governing Body on a monthly basis or more often as required.

AREAS OF RISK/STUDY: The Committee has identified three major areas of risk/study. These areas are Quality Improvement, Risk Management and Patient Satisfaction. Separate risk analysis and program definition has been performed for each area and is summarized herein.

## **EYE SURGERY CENTER OF NORTHERN NEVADA**

1. Quality Improvement consists of three significant components: Quality of Care (including Peer Review), Cost of Care, and Administrative issues. These are discussed in turn.
  - A. Quality of Care. Within this component, numerous aspects of care exist which require regular and consistent review and evaluation. The Committee has designated the following elements as requiring daily attention:
    - a. Verify equipment function within proper limits for: Refrigerators, Defibrillator, and Surgical Lasers. Confirm cleanliness of all equipment.
    - b. Nursing care is appropriate with respect to IV starts, medication administration, patient preparation, and turnover time.
    - c. Medical records are complete and accurate, physically present in the operating suite and legible. Ascertain that the surgeon verifies all laboratory results, if applicable.
    - d. Patient condition and care is documented with respect to:
      - i. Proper placement of bed side-rails in the up position.
      - ii. Any ambulation problems post-operatively.
      - iii. Nausea or vomiting.
      - iv. Maintenance of continuity of surgery.
      - v. Glucose testing performed on all known diabetic patients.
      - vi. Blood oxygen levels below 90 percent are properly documented and evaluated prior to surgery.
    - e. Anesthesia care is documented as to the success of conscious sedation (when utilized), local or regional blocks (when utilized), general anesthesia (when utilized), volume of medication administered, and mixture of anesthetic utilized. (Refer to daily QI Tracking Record for indicators.) Additional indicators include existence of:
      - i. Tooth damage
      - ii. Stridor, laryngospasm, obstruction
      - iii. Prolonged respiratory depression
      - iv. Pulmonary aspiration
      - v. Cardiac arrhythmia
      - vi. Hypertension
      - vii. Prolonged sedation
      - viii. Orbital bleed

## **EYE SURGERY CENTER OF NORTHERN NEVADA**

- ix. Vomiting > 3 episodes
  - x. Perforation of globe
  - xi. Retrobulbar hemorrhage
  - xii. Adequate sedation
  - xiii. Documentation of controlled drug administration
  - xiv. Related complications
  - xv. Other unexpected outcomes as recognized
- f. This data is to be collected daily and compiled monthly. Following monthly compilation, the data should be reviewed by the Clinical Director of ESCNN to identify any adverse trends or real or potential problems or concerns that may affect the quality of patient care.
- g. Issues so identified will be considered quality improvement problems and the appropriate study methodology, as described in Section 1 of the Plan, should be applied.
- h. Other elements of the operation of the Center designated by the Committee for periodic review include:
- i. Nursing staff should be monitored to insure that current licensure is maintained and professional development activities are adequate to insure skills remain sharp. When required, ACLS status is ascertained and appropriate levels of productivity are achieved. Current copies of licenses are to be obtained and maintained in each individual's personnel file. Annual performance evaluations will be conducted.
  - ii. Patient care concerns in this category include comfort of medications administered, safety issues (including falls), all required transfers to a hospital, all unplanned vitrectomies, treatment of pathology specimens, and all nosocomial infections.
  - iii. An additional concern to be addressed at least annually is adequate documentation of the appropriateness of the surgical decision.
- i. The final element designated by the Committee, as a required element of quality improvement monitoring is peer review. It is the responsibility of the Clinical Director of ESCNN to establish appropriate peer review relationships in the areas of surgical care and anesthesia care. Further, appropriate peer review of the medical records and procedures of the Center shall be performed at least annually.



## **EYE SURGERY CENTER OF NORTHERN NEVADA**

- j. Responsibility for the implementation of this segment of the Plan is placed upon the Clinical Director of ESCNN.
- k. Cost of Care. These issues are critical to the continued successful operation of the Center. The Committee notes the relationship of these issues to quality of care and the following elements are believed to exhibit significant cost of care concerns:
  - i. New equipment purchases. Scope for mandatory study is established as \$15,000.00
  - ii. Cost of existing or planned new services, including the impact of new regulatory requirements.
  - iii. Change or replacement of equipment. Scope for mandatory study is established as \$15,000.00
  - iv. Purchasing methods, particularly as they relate to regulatory compliance (e.g., “bundling”).
  - v. Monitoring and control of cost per case for surgery and other procedures as their significance warrants.
  - vi. Responsibility for the implementation of this segment of the Plan is placed upon the Clinical Director of ESCNN.
- l. Administrative. This set of issues includes operational, financial and personnel management elements. Specific concerns of the Committee include:
  - i. Operational – adequate staffing, repair and maintenance of plant and equipment, and establishment and implementation of operating procedures for non-medical employees.
  - ii. Financial – control of financial assets (particularly cash and inventory), review system of internal accounting control for appropriateness and efficacy, preparation of periodic financial statements on a timely and consistent basis, regular analysis of collections and accounts receivable and profitability of the company.
  - iii. Personnel Management – training and supervision of staff, continuing education of medical staff and key non-medical employees, regular program of career counseling and salary administration and compliance with regulatory requirements affecting employees (e.g., OSHA, COBRA, Fair Labor Standards, etc.).

## **EYE SURGERY CENTER OF NORTHERN NEVADA**

- iv. Responsibility for the implementation of this segment of the Plan is placed upon the Clinical Director of the Center.
- B. Risk Management reflects concerns that affect the lives and welfare of the patients and employees of the Center. The Committee has identified the following elements of physical security, patient care, and corporate liability for study pursuant to mandate of this Plan. Each element so identified must be addressed at least annually, or more frequently as circumstances warrant:
  - i. Physical Center maintenance and security, including control of ingress and egress.
  - ii. Life safety systems and procedures, including alarms, drills, and disaster planning.
  - iii. Regulatory compliance, particularly OSHA and DEA requirements.
  - iv. All patient or employee incident reports involving safety, injury, or misconduct.
  - v. Adequacy and completeness of insurance coverage, including property and casualty, medical malpractice, general corporate liability, business overhead, group health, and group disability, if applicable.
  - vi. Procedures involving acquisition, utilization and disposal of controlled substances.
  - vii. Disposal of medical waste.
  - viii. Exposure control and other staff health issues.
  - ix. The Clinical Director and designated Risk manager will share responsibility for the implementation of this segment.
- C. Patient Satisfaction. The Clinical Director will be responsible for the design, implementation, and evaluation of an ongoing system to monitor patient satisfaction with various aspects of the care and services provided by the Center.
  - i. It is anticipated that this program will be conducted by the Center, will provide both qualitative and quantitative data and will annually cover the performance of all health care providers, specifically including all licensed physicians individually. The performance of other employees may be addressed as a group, e.g., nursing care, reception personnel, etc.

## **EYE SURGERY CENTER OF NORTHERN NEVADA**

- ii. The results of all such studies will be communicated to the Governing Body, President and Staff of the Center during regular staff meetings as soon as such data is available.

REPORTING OF RESULTS: The Committee is responsible for dissemination of QI/RM data to the Governing Body, President, management and staff of the Center. The available meeting and training schedule should be utilized to the maximum extent possible.

1. This schedule includes the scheduled staff meetings that are available for both the reporting of results and findings and also for in-service training. The Governing Body will meet quarterly in accordance with their procedures and written minutes of these meetings will be maintained in the corporate records.
2. It is the intent of the Committee to formally present the QI/RM plan to the Governing Body for approval on an annual basis. Further, the Governing Body will review the results of QI/RM activities on a quarterly basis. These activities will be documented in the minutes of the meeting of the Governing Body.
3. Finally, the Governing Body will periodically review the composition of the Committee. Appointments and reappointment to the Committee shall be approved by the Governing Body and appropriately documented in the minutes.

## EYE SURGERY CENTER OF NEVADA

### SAFETY COMMITTEE

The Safety committee will be comprised of the physician administrator, a registered nurse and one ancillary person. This committee will meet quarterly in conjunction with the Quality Assurance committee meeting.

It will be the responsibility of the Safety committee to ensure that all practices involving patient care are carried out according to policies and procedures established by the facility. At all times the safety of patients at the facility will be the top priority. It is also the responsibility of the Safety committee to maintain the safety of all employees, patient families, visitors and physicians by ensuring these policies are followed.

Review of any breaks in the policies and procedures; safety issues identified by direct observation or action; and events will be done and resolution of the situation enacted and corrected. Follow up on these issues will be the responsibility of the committee.

## EYE SURGERY CENTER OF NEVADA

### SAFETY

The Safety committee is responsible for ensuring that all policies and procedures related to the safety of patients, families, physicians and staff of the facility are being followed. They are to report to the Quality Assurance committee on a quarterly basis.

Any situation observed by an employee or member of the professional staff that appears to be a potential safety hazard will be reported to the Safety officer. When possible, the situation will be rectified immediately.

All electrical equipment will be checked on a semi-annual basis for electrical safety by the biomed engineering company. All equipment will be maintained with a preventative maintenance program with the same company. Documentation will be kept for two years. Any malfunctioning equipment will be removed from service immediately and repaired or replaced. Documentation will be kept and appropriate forms will be completed to meet the FDA and State agency requirements for the Safe Medical Devices Act and Sentinel Event reporting.

All personnel will be required to participate in fire drills and attend an annual fire and electrical safety inservice session.

The policies and procedure guidelines for the disposal of sharps, infectious waste and contaminated linens will be followed by staff and providers alike.

No patients who have active, known communicable disease process will be admitted to the facility for a procedure. Any post admission discovery will be reported following State guidelines.



TYPE: SAFETY  
TITLE: PATIENT SAFETY PLAN  
ADOPTED: 8/1/2006  
LAST APPROVED: 01/12/2016

**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.

#### 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, will be collected and utilized in the program.

#### 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 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.



TYPE: SAFETY  
TITLE: PATIENT SAFETY  
ADOPTED: 8/1/2006  
LAST APPROVED: 01/12/2016

**SUBJECT: PATIENT SAFETY**

**POLICY NUMBER: 7.3**

**Purpose:**

To identify and eliminate potential safety hazards, thereby reducing risk to patients, personnel, and visitors.

**Policy:**

Patient safety refers to a systematic program to minimize preventable physical injuries, accidents, and undue psychological stress during the visit. The nursing practice for safety standards is as follows:

1. The procedure nurse always identifies the patient using two patient identifiers, such as by checking the wristband with the patient's chart and procedure schedule. In addition, the RN always verifies patient identification through verbal communication with the patient.
2. Staff shall use only acceptable abbreviations for medication orders.
3. Patients are on beds which are at the lowest level, with the side rails up at all times until the procedure starts.
4. 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 year thereafter, by a CME.
5. Proper placement of the electrosurgical ground pad is essential to prevent electrical burns. Coagulation/cutting settings on the electrosurgical units are set at the lowest setting and gradually increased.
6. Flammable solutions (i.e. alcohol) are not to be utilized when electrocautery is in progress.
7. All Biohazardous wastes, including glass, are placed in the special collection container marked "Biohazardous Waste" and disposed of by a contracted service provider.



8. Under normal conditions, extension cords shall not be used. Temporary use of extension cords may be permitted under specified conditions and with proper approval.
9. Use of adaptors within the Center is prohibited.

<b>Safety Management Plan</b>	<b>EN 1001</b>
<b>Center:</b> Ear, Nose and Throat Surgery Center	<b>Standards Reference:</b>
<b>Date Effective:</b> 2/2015	<b>Date of Revision:</b> 3/16
<b>Approved By:</b> Thomas F. Meagher RN	

### **POLICY:**

The Surgery Center will provide guidelines and implement proactive practices, which provide a safe environment of care in relation to property, equipment, patients, personnel and the public.

### **PROCEDURE:**

1. Employees are responsible for;
  - Intervention when, safety conditions pose a threat to life or health, or threaten damage to equipment or buildings
  - The continuing maintenance of the facility property, eliminating hazards upon discovery
  - Reporting equipment or maintenance problems and incidents of property damage to the Safety Officer or Administrator/ Clinical Director upon discovery
  - Reporting injuries and illness to the Administrator/Clinical Director
  - 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 Improve Committee are responsible for:
  - Environment of Care development, implementation and monitoring.
  - Report of Safety Surveillance and activities to the Quality Assessment Committee.
  - Annual review of the Environment of Care policies and guidelines for objectives, scope, performance and effectiveness.
  - Compliance with the current version of the NFPA, Life Safety Code (LSC) for maintaining and supervising the facility grounds, buildings and equipment.
  - Maintain equipment and utilities following a preventative maintenance schedule and assuring that a preventative maintenance list of all equipment and history is maintained.

- Maintain sufficient light in the parking and entrance areas to reduce the potential for falls and security concerns.
- Maintain signs and emergency systems to meet the needs of the visual and hearing impaired.
- Maintain smoke free environment.
- Provide facility cleaning, maintenance, and inspection, following a schedule for daily, weekly, monthly, semi-annual and annual activities.
- Construction and Renovation (Interim Life Safety Plan)
  - Meet the existing ambulatory health care occupancy health code requirements for construction or renovation.
  - Train staff in alternative safety processes including the use of new specialized equipment and space.
  - Train staff to compensate for changes in Life Safety Plan
  - Provide increased facility safety monitoring with construction and renovation included reference to the NFPA, Life Safety Code (LSC)
  - Inspect and monitor components of Life Safety Plan weekly or more frequently if indicated.
- 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.
  - Assign a Safety Officer to maintain risk and hazard surveillance.
  - Record Hazard surveillance
  - Report environmental hazard and safety surveillance to the Quality Improvement Committee. Provide follow-up to staff concerning safety issue recommendations.
- Report and document patient, personnel or visitor injury, and occupational illness. Document incidents on an Event Report.
  - Investigate and evaluate each report for an opportunity for performance improvement.
  - Include injuries and occupational illness in the report to the Quality Improvement Committee.
- Address a product safety recall upon notification.
  - Inventory and remove recalled product from possible use.
  - Notify affected medical staff and evaluate a substitute product.
  - Inventory patients who may have received a recalled medical device from implant logs or records.
  - Consult with the Medical Director and/or Quality Improvement 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 the Chairman of the Quality Improvement Committee reports the incident to the Medical Executive Committee.

- Provide Safety Education and Training at orientation and at least annually thereafter which address general safety processes; area specific safety and job related hazards.
- Provide Safety Guidelines in the General Orientation including:
  - Review of Safety Policies and Guidelines
  - Body Mechanics
  - Hazardous Materials Communication
  - MSDS/ Hazardous Waste
  - Safety Risk / Responsibilities
  - Equipment Safety/Operations Manuals
  - Emergency Preparedness
  - Utility Systems and Electrical Safety
  - Infection Control/Exposure OSHA
  - Reporting of Sentinel Events
  - Variance, accidents/injuries, Security and Safety concerns
  - Fire and Life Safety
  - 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
- Provide updates when new equipment is introduced.
- Compliance with the state requirement for the tracking, reporting, management and proactive avoidance of sentinel events, to include but not limited to the definition of event, the analysis of events, the reporting of events and the prevention of events as required by the State of Nevada. In the event of a suspected sentinel event the Patient Safety Officer will apply the state published Algorithm to determine that an event is a sentinel event and should be reported. A Sentinel Event means an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including without limitations, 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.
- Review General Safety Guidelines annually



**Environment of Care (EC)**

**DURANGO OUTPATIENT SURGERY CENTER**

---

**Effective Date: 07/16/08**

**Review/Revision Date: 06/11, 3/12, 3/13, 12/14, 12/15**

**Policy Number: EC 3001**

**Policy: Safety Management Plan**

---

**Policy:**

The Administration of Durango Outpatient Surgery Center and the Governing Body believe in a strong commitment to providing a safe and secure environment for patients, visitors, and staff. 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.

**Procedure:**

In order to achieve these objectives the Safety Management Plan includes the organizations process for:

- Establishing, supporting, and maintaining a safety management program that is based on monitoring and evaluation of organizational experience and applicable practice;
- Providing a physical environment free of hazards and for managing staff activities to reduce the risk of human injuries; ensuring that emergency service areas are clearly identified and easily accessible.
- Establishing a risk-assessment program that proactively evaluates the impact on patient and public safety of the Center and interacts with the Building Management Company to ensure their cooperation with the objectives of the center in complying with safety issues of the building.
- Providing a safety officer appointed by the Center Administrator and qualified by experience or education, who is responsible for developing, implementing, and monitoring the organization's safety management plan. The individual also will intervene whenever a condition exists that pose as an immediate threat to life or health or pose a threat of damage to equipment or Center.
- Establishing a safety committee composed of representatives of administration, and staff members representing both the clinical department and business office.

- Reporting and investigating all incidents that involve property damage, theft, occupational illness, and patient, personnel, or visitor injury.
- Requiring departmental safety policies and procedures that are distributed, practiced, and enforced.
- Reviewing all departments' safety policies and procedures as frequently as necessary, but no less than annually; adding new policies as the need requires after approval from the MEC and Governing Body.
- Promoting an on going hazard surveillance program, including response to product safety recalls.
- The center will adopt and use both clinical and environmental checklists to improve the safety for each patient, visitor and employee and comply with the checklist policy.
- Using safety related information in the orientation of new employees and the continuing education of all employees to include information on a Culture of Safety;
- Requiring an annual evaluation of the objectives, scope, performance, and effectiveness of the documented safety management plan.

### **Safety Management Responsibilities**

#### **A. Administration/Governing Body**

The Administration/Governing Body's responsibility is to assure a safe environment for patients, personnel, and visitors by requiring and supporting the establishment and maintenance of an effective safety management plan. The Administrator appoints a safety officer or safety chairman to oversee the safety management plan. The Medical Executive Committee will be informed about safety issues and actions taken to resolve these issues on a quarterly basis. After the Medical Executive Committee has reviewed the safety report it will be forwarded to the Governing Body. This will allow the Governing Body to establish standards of performance for the various aspects of the safety management plan, such as; legal requirements, ethical standards, and staff competence. The long-term result is a greater understanding of what types of problems are important to the organization and what methods are effective in addressing them.

#### **B. Safety Officer**

The Safety officer is a qualified individual appointed by the Center Administrator and is responsible for the development, implementation, and monitoring of the safety management plan. The Safety Officer manages an ongoing Center wide process to collect and evaluate information about deficiencies and opportunities for improvement in the environment of care management program. An environmental tour will be made of the Center monthly to ensure maintenance, supervision, and safe use of the Center by staff, physicians, patients and visitors. The Safety Officer works with appropriate staff to implement the safety committee recommendations and monitor the effectiveness of recommended changes. The Safety Officer may delegate the safety program functions to members of the staff and/or Safety committee.

### C. Safety Committee

The safety committee will develop written policies and procedures to enhance the safety within the Center. Monitor equipment and utility preventive maintenance and inspection procedures, and monitor the education and training of users to protect against the failure or user error will be done by the committee.

### D. Department Supervisors, Clinical Director and Administrator

Department Supervisors, Clinical Director and the Administrator have direct authority and responsibility for both the safe actions of employees and the safe performance of the machine, equipment and operations within their department. 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:

- The Clinical Director or Administrator will complete the quarterly EOC report.
- Enforce Center 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 in the hazards associated with assigned duties and how to avoid injuries.

- 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. Instill safety awareness in each employee by personal example, regular personal contacts, and group meetings.
- Motivate employee interest and participation in the safety program by setting an example and soliciting suggestions.
- Cooperate fully with safety officer/safety committee in the promotion of safety activities. Seek assistance from the safety officer relative to safe practices and procedures.
- Ensure that employees receive all required safety training and education. Assist in conducting training as needed.
- Know and instruct employees in emergency actions, including evacuation procedures from all work areas.
- Ensure that all injuries are reported and, if necessary, treated immediately.
- Investigate all accidents and incidents in their area to determine whether injuries resulted, and make the required reports.
- Participate actively when called to serve on the safety committee. Further, appoint an alternate from the department who can attend committee meetings and represent the department in their absence.

E. Materials Manager

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 a part of every operation and function.

The Materials Manager works closely with the supervisors to:

- Have new or relocated equipment and instrumentation checked and approved by Bio Med services before it is placed in operations.
- Ensure that adequate safety equipment and protective devices are provided for each job in each work area, as required, and that such equipment is properly used and maintained by the employees.
- Perform monthly FDA recalls and when notified. Results are presented to the safety committee.

E. 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 will:

- Learn the safe and correct way to perform their assigned duties and shall ask their supervisor anything about which they are in doubt
- Perform their jobs in a safe, responsible manner using required safety devices and personal protective equipment provided by the health Center, 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
- Report any accident, personal injury, or patient complaint regarding the health or safety practices, no matter how slight, to their supervisor immediately
- Report any hazard observed and suggest to the supervisor better and safer ways to perform tasks
- Always be fit for their assigned duties by practicing good health habits and personal cleanliness
- Practice good housekeeping at all times; keep equipment, tools, materials, instruments, and work areas clean and orderly
- Attend all required safety-related training
- Know what actions to take in case of fire or other emergency situation in their work area(s)
- Comply with no smoking requirements.

**POLICY:****DIGESTIVE HEALTH CENTER**

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:

1. General safety– Life Safety Management Plan, Infection Control Policy Online, Inclement Weather and Emergency Situations
2. Security – Security Management Plan Policy Online
3. Hazardous waste and materials– Hazard Materials and Wastes Management Plan Policy Online
4. Emergency preparedness– Disaster Safety Management Plan Policy Online, Inclement Weather and Emergency Situations, Bomb Threat, Bioterrorism Plan
5. Fire safety Fire Plan Policy Online
6. Environment of care– Facilities and Environment Policy Online
7. Medical equipment management– Medical Equipment Management-Operation-Repair Policy Online
8. Life safety– Life Safety, Disaster Safety, Fire Plan Policies Online
9. Utility systems– Facilities and Environment Policy Online, Physical Plant Utilities Maintenance, Utilities System Management Plan
10. Patient safety– Life Safety, Infection Control, Disaster Safety Policies Online, Risk Management Plan, Information Management Plan
11. Pharmacy– Pharmacy Policies Online
12. 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.

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:

1. Monitoring and supervising all grounds and equipment
2. Monitoring of infection control practices on a continuous basis with quarterly reporting to the QAPI
3. Conducting risk assessments that proactively evaluate the impact of buildings, grounds, equipment, occupants and internal physical systems on patient and public safety
4. Examining safety issues by appropriate representatives from administration, clinical services and support services
5. Reporting and investigating all incidents of property damage, occupational illnesses and patient, personnel or visitor injury
6. Conducting ongoing hazard surveillance, including response to product safety recalls
7. 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

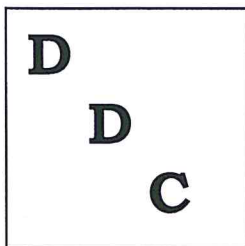
Implementing an orientation and education plan that addresses:

1. General safety processes
2. Area specific safety
3. Specific job related hazards
4. Safety related information through new employee orientation

Conducting ongoing monitoring of performance to assess:

1. Staff knowledge and skills
2. Monitoring and inspection activities
3. Emergency and incident reporting
4. 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.



**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. All patients will be identified at each patient encounter using two (2) identifiers that include the patients name & birth date.
- B. All caregivers to the patient shall, before & after each patient encounter perform hand hygiene.
- C. All providers shall be fully informed of their patient's physical status as it pertains to their surgery/procedure.
- D. The surgery/procedure is appropriately performed (correct site/correct procedure) and clinically accurate and the informed consent reflects this.
- E. A final "Time Out" verification will be performed before any procedure requiring formal consent.
- F. Each patient will have a History & Physical examination documented in their chart within 7 days of their procedure.
- G. Each patient will complete the Medical History Questionnaire prior to his or her procedure.
- H. All patients will receive a copy of the Patient Rights and Responsibilities at the time of scheduling their procedure.
- I. All medical staff is CPR certified, and aware of the location and use of all emergency equipment. All DDC Physicians are ACLS certified.
- J. 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.
- K. 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.
- L. Patient safety checklists shall be employed throughout the patients stay in the facility. These items are designated by √ on the Endoscopy Record.
- M. Patients will be educated on post operative self management, including aftercare concerning diet, activity & wound care.
- N. Instructions provided on the use of the medications prescribed for use after the procedure.



- O. Any other pertinent instructions specific to the procedure performed.
- P. Any questions initiated by the patient will be answered as completely as possible.
- Q. Each patient will meet the required discharge criteria set forth by DDC, and 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.
- R. A written copy of discharge instructions will be issued to each patient prior to discharge, providing instructions for after care including precautions, resumption &/or use of newly prescribed medications and contact information for post op complications and after hour care. A copy of this document will become part of the patient's record.
- S. The facility staff will make a follow up appointment for the patient as ordered by the physician.
- T. Each patient will be contacted within 48 hours after having their procedure to ensure that they are not experiencing any complications related to the procedure.
- U. The Patient Safety Committee shall meet monthly.

Revised 2/16/2010, 8/30/2011

References:

1. CDC Guide to infection prevention in outpatient settings: Minimum expectations for safe care.
2. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings



**Origination:** 05/2015  
**Last Approved:** 12/2015  
**Last Revised:** 05/2015  
**Next Review:** 12/2018  
**Owner:** Name has been removed  
based on NRS439.843.  
**Policy Area:** QAPI-RM-IFC  
**References:**

## Quality Assessment & Performance Improvement Program & Patient Safety Plan

**Coronado Surgery Center** believes that Quality and Patient Safety is everyone's responsibility. This includes delivering care consistent with professional standards; providing and maintaining a safe patient environment; and remaining fiscally responsible. The Facility Board of Managers, Medical Staff, and administrative leadership are dedicated to patient safety and quality improvement. They are charged with the responsibility of overseeing the development and implementation of a quality plan consistent with the organization's mission, vision, and values. The Facility Board of Managers and Leadership will review the effectiveness of the Quality Assessment and Performance Improvement and Patient Safety Plan, at a minimum, annually. The Board of Managers will give final approval of the plan and priorities identified.

The Board of Managers must ensure the Quality Assessment and Performance Improvement Program:

1. Is defined, implemented, and maintained
2. Addresses the Facility's priorities and that all improvements are evaluated for effectiveness.
3. Specifies data collection methods, frequency, and details
4. Clearly establishes its expectations for safety
5. Sets expectations and priorities regarding performance improvement while adjusting priorities in response to urgent or unusual events
6. Allocates adequate resources for improving organizational performance and improving patient safety
7. Measures and assesses the effectiveness of performance improvement and safety activities

The Quality Assessment and Performance Improvement and Patient Safety Plan promote the highest quality of patient care and services within the Facility. The scope of the Quality Assessment and Performance Improvement and Patient Safety Plan addresses all areas, including clinical contracted services provided by lab, pharmacy, etc. The Facility will put into operation the plan within its scope of services and population served, utilizing the following guiding principles:

### 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.

## **Prioritization and Accountability of Performance Improvement and Patient Safety**

The Board of Managers, in collaboration with Facility Leadership and the Medical Staff, sets priorities for performance improvement and safety.

### **Performance Improvement Focus**

The program is designed to be ongoing and to demonstrate measurable improvement in patient health and outcomes; improve patient safety by using quality indicators or performance measures associated with improved health outcomes; and identify and reduce medical errors.

The Facility strives to achieve optimal clinical outcomes for all its patients while providing care in the safest environment possible. Indicators used to measure quality will be outcome indicators that measure results of care, process of care indicators that measure how often the standard of care is met in various processes across the Facility, and patient perception indicators that measure a patient's perception of their patient experience.

At a minimum, the Facility collects data on the following:

1. Operative or other procedures that place patients at risk of disability or death
2. All significant discrepancies between pre-operative and post-operative diagnosis, including pathologic diagnoses
3. Adverse Events related to using moderate or deep sedation or anesthesia
4. Incidence of Resuscitation and its results
5. Medication Errors
6. Adverse Drug Reactions
7. Patient perception of the safety and quality of care, treatment, services, and communication
8. Infection Control and Surveillance
9. Patient Burns
10. Patient Falls
11. Prophylactic Antibiotic Timing

12. Hospital Transfer/Admissions
13. Wrong Site, Wrong, Side, Wrong Patient, Wong Procedure, Wrong Implant
14. Unintended Retained Foreign Object

In addition to the above indicators, the Facility will prioritize performance improvement activities to assure that they are focused on high-risk, high-volume, or problem-prone areas. The Facility will focus on issues of known frequency, prevalence or severity, and shall give precedence to issues that affect health outcomes, quality of care, and patient safety.

## Components of Performance Improvement Program

Quality Assessment and Performance Improvement (QAPI) is a continuous process. The QAPI program will be proactive, comprehensive, ongoing, and data driven.

The goal of QAPI involves:

1. Identification and measurement of variances in current practice and services that can lead to less than optimal performance
2. Identification and implementation of changes to enhance existing performance
3. Consistent monitoring of changes to ensure sustained gains

The data collected will be used to monitor the effectiveness and safety of services and quality of care provided and to identify opportunities that could lead to improvements and changes in patient care.

Data will be analyzed to monitor the Facility's performance and to determine what the data suggests about the Facility's quality of care and effectiveness of safety of its services. Analysis will take place at regular intervals to enable detection of problem areas in a timely manner. Investigation into root causes for any adverse event will be conducted. Following the analysis of data and identification of opportunities for improvement, the Facility will develop specific changes in its policies, procedures, equipment, environment, process, etc. to accomplish improvements in the identified areas of weakness. The Facility will implement preventive strategies designed to reduce the likelihood of an adverse event.

Implementation of strategies to ensure the improvements made are sustained over time will be done. Staff will be made aware of strategies adopted for prevention of adverse events.

Combinations of methodologies are used to provide a systematic approach to process improvement. Utilization of the PDCA (Plan, Do, Check, Act) problem-solving framework, throughout the Facility, enables all employees to systematically work through performance improvement initiatives.

At a minimum, the Facility will be required to have two distinct performance improvement initiatives annually that reflect the scope and complexity of service provided. Documentation of the projects will include the reason for implementing the project and a description of the project's results. Records will be kept on the chosen performance improvement projects.

The Quality Indicator Dashboard will be reviewed and updated at least annually by Quality Assessment and Performance Improvement Committee and the Board of Directors.

Performance Improvement initiatives and quality indicators will be prioritized based on the following criteria:

1. High risk, high impact, and problem prone areas

2. Indicators with performance remaining below benchmark
3. Indicators required for reporting by regulatory and accrediting agencies
4. Recommendations from the National Quality Forum and the Agency for Healthcare Quality and Research

Indicators will be scored utilizing a red (below benchmark), yellow (approaching benchmark) or green (at or better than benchmark) spotlight scoring system. External benchmarks will be used when available and internal benchmarks will be developed if no external ones are available.

Thresholds for yellow and red scores will be developed by indicator; any indicator performing at or above the indicator will be scored as green. Indicators scoring red for three consecutive months or greater will be required to begin a ninety (90) day performance improvement action plan. The Administrator or leader for the area will oversee the plan and provide necessary resources for the project.

## **Components of Patient Safety Program**

Patient Safety is a priority at the Facility. The Patient Safety Plan is designed to support and promote the Facility's mission to provide safe, quality patient care. The plan engages staff, medical staff, patients, and visitors in activities and practices designed to promote safety and prevent patient injury and harm associated with medical errors and hazardous conditions in the health care setting. An important aspect of Performance Improvement is the identification and management of processes and behaviors leading to potential or actual patient harm. The Facility Patient Safety Program includes the ongoing assessment, tracking, and trending of patient safety events, and determination of further action, should action be deemed necessary.

The authority of the Patient Safety Plan rests with the Board of Managers (BOM). The BOM delegates authority to the QAPI Committee to implement and maintain the activities described in the plan. All staff share responsibility and accountability to employ safe patient practices in alignment with the Facility policies and procedures.

## **Program Distinguishing Characteristics**

### **Proactive Approaches**

The Facility engages in proactive risk reduction approaches to (re)design processes to improve patient safety before an event occurs with potential or actual harm to patients. The approaches include:

1. Performing a criticality analysis or failure mode effects analysis (FMEA)
2. Obtaining stakeholder, physician, and staff information about potential safety issues
3. Documenting "near miss" events in variance reports
4. Formalizing mechanisms to analyze care and revise care processes under the guidance of the QAPI and BOM authority
5. Adopting best practices, clinical practice guidelines, and preventive approaches endorsed by regulatory, accreditation, and professional associations
6. Prioritizing the annual performance improvement and safety initiatives

## **Patient/Family Education and Involvement**

The Facility encourages the patient and family to become partners and participants in their care. The patient participation strategies include:

1. Active participation in correct patient, procedure, site verification procedures
2. Notification of patient rights and responsibilities
3. Obtaining information about pre-procedure medications
4. Enlisting patient and family feedback, perceptions, and concerns for safety and well-being while receiving care and after discharge by way of post-op phone call and patient survey.

## Health Care Team Education and Involvement

Each member of the Care Team is considered an advocate for patient safety and error prevention. The Facility approaches include:

1. Safety-related orientation and training
2. Expectations of reporting potential and actual events which may cause patient harm (variance reporting)
3. Safety-oriented communications and partnership with patients evidenced in patient encounters
4. Participation in QAPI processes including routine safety-related data collection and analysis (infection surveillance, the Facility safety surveillance)

The Board of Managers and the Facility leadership have the ultimate authority and accountability to conduct a program which positively influences patient safety. The program implementation and oversight is under the leadership of the QAPI Committee with the participation of staff responsible for patient safety, risk management, and quality improvement functions.

The Patient Safety Plan and Program exists in concert with the Quality Assessment and Performance Improvement Plan/Program and the Risk Management Plan. Regular reports and recommendations are submitted to the Board of Managers. The effectiveness of the Plan and Program are evaluated annually by the QAPI Committee and Board of Managers. The overall effectiveness and efficacy of the program is evaluated annually by reviewing the following:

1. Improvements in high-risk and core care process selected for risk reduction
2. Results of and action on patient perception data
3. Impact of Patient Safety Goal compliance
4. Results of stakeholder and staff involvement in patient safety and error reduction approaches
5. Regular reports and recommendations are submitted to the Board of Managers
6. Impact of increased reporting and recognition of patient errors, near misses, or hazardous conditions

Types of patient safety or medical errors included in review and analysis include, but are not limited to: actual or near-miss events; potential and actual adverse drug events; sentinel events (reference: Sentinel Event Management Policy).

Any sentinel event or undesirable outcome will trigger an immediate response from the Director of Nursing as well as other Senior Leadership, as appropriate. A Root Cause Analysis (RCA) is conducted on all sentinel events and an action plan formulated to identify strategies the organization will implement to mitigate the risk of similar occurrences in the future. All other event types are reviewed and action taken as appropriate (reference sentinel event management policy).

Aggregate variance report information will be presented quarterly to the Board of Managers. Should an issue or trend be identified, direction and resources for further investigation or a ninety (90) day action plan, will be



provided under the guidance of the committee. In addition to routine patient safety information reporting per the Quality Assessment and Performance Improvement Reporting Calendar, trends or concerns will be reported to the committee as they are identified. However, any member of the Board of Managers or Senior Leadership can request a further drill down of patient safety concerns, at any time.

## **Performance Improvement and Safety Structure and Results Reporting**

Quality information flows through a reporting structure as identified below. Significant findings, actions, and recommendations from quality management activities are reported to the Senior Leadership Team and the Board through the established reporting structure.

### **Board of Managers**

The Board of Managers has the ultimate authority and responsibility for the oversight, approval of, and participation in the Quality Plan. During each meeting of the Board of Managers, a portion of the agenda will be dedicated to updates and reports on patient safety and performance improvement. In addition, the Board of Managers is responsible for the review and approval of the Performance Improvement and Safety plan annually.

### **Quality Assessment and Performance Improvement (QAPI) Committee**

The Quality Assessment and Performance Improvement Committee receives reports from the Safety Committee and Infection Control Committees; facilitates the implementation of the strategic quality direction; oversees ongoing measurement, assessment, and improvement of current performance improvement initiatives; receives reports of each of the Facility's patient safety adverse events; prioritizes improvement activities; receives reports and coordinates accreditation efforts; prioritizes improvement activities; reviews and revises the annual plan; completes an annual review of quality and safety performance; serves as a resource for learning and applying new quality techniques; acts as a liaison among the Facility Board of Managers, Medical Staff and Administration with respect to performance improvement; receives performance improvement information; and provides oversight for the annual Performance Improvement and Safety Plan.

### **Reports to:**

the Facility Board of Managers

### **Meeting requirements:**

The Quality Assessment and Performance Improvement Committee shall meet quarterly.

### **Reference**

Centers for Medicare and Medicaid Conditions for coverage 416.43 effective 12-30-09  
CMS-1525-FC ASC Quality Reporting Program final rule November 2011

# Associated Forms

Patient 1<sup>st</sup> Handout

ASC Dashboard – see [facilitytoolbox.com](http://facilitytoolbox.com)

## Attachments:



[Patient 1st Handout Form](#)

Names in this page have been removed base on NRS439.843.	Approver	Date
	Director of Clinical Operations	05/2015
	Director of Nursing	12/2015
	Administrator	12/2015

COPY



# Centennial Surgery Center

Patient Safety Plan 2015

Prepared by: Name has been removed base on NRS439.843.

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 Safety 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:
  - o Identification of high risk areas
  - o Potential or actual adverse event
  - o Proactive risk prevention strategies
- Method
  - o Identification and prioritization of safety concern
  - o Data collection
  - o Develop action plan
  - o Implementation
  - o Reporting of data
  - o Follow up
- Process Improvement Tools Utilized
  - o PDCA: (Plan, Do Check, Act) Focus on process improvement
  - o FMEA: (Failure Mode Effect Analysis) Systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk.
  - o 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

**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 1/2016

**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 Control in Reprocessing of Flexible Gastrointestinal Endoscopes 2015
- c. Society of Gastroenterology Nurses and Associates, Inc. (SGNA) Guideline for Use of High Level Disinfectants and Sterilants for Reprocessing Flexible Gastrointestinal Endoscopes 2013
- d. American Society for Gastrointestinal Endoscopy (ASGE) Infection Control during GI Endoscopy 2008
- e. Center for Disease Control (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007
- f. CDC Guide to Infection Prevention for Outpatient Settings 2014
- g. Association for Professionals in Infection Control and Epidemiology (APIC) Guide to the Elimination of Clostridium difficile in Healthcare Settings 2013
- h. 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
- f. Equipment Processing: Cleaning, Disinfection, High Level Disinfection and Sterilization

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.

*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.*

- 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 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.

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.

*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.*

- 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.

*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.*

# Box Canyon Surgery Center

Policy Name:	<b>SAFETY MANAGEMENT &amp; RESPONSIBILITY</b>
Section:	Safety
Policy #:	IV.4.1
Purpose	Staff Education

Approved Date	Reviewed Date	Revised Date
2-3-09	2-23-10, 2-23-11, 2-6-12, 2-4-13	

- The Governing Body of the center has approved the following safety management program to help ensure we maintain a physical environment free of hazards for all staff, physicians, patients and visitors.
- The Governing Body has appointed the Clinical Director to act as the official safety officer. He/she will monitor the effectiveness of the safety policies and procedures through functions of the TQM program.
- The objective, scope, organization and overall effectiveness of the safety management program will be evaluated at least annually and revised as necessary.
- It is the responsibility of any employee or physician who sees a safety hazard or potential hazard to immediately notify the Clinical Director (or Business Manager in Clinical Director's absence). The Clinical Director will then investigate the report, take appropriate corrective action and document findings. A follow-up report will follow to the TQM committee.



# 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 (AAHC/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.

# ALTA ROSE SURGERY CENTER

## POLICIES AND PROCEDURES

SECTION: N-140

DATE: 07/03

REVIEWED: 6/2015

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.

<b>Section Title:</b> Facilities And Environment	<b>Section:</b> 8
<b>Subject :</b> Safety Management Program	<b>Policy:</b> 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

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 1 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED:

**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 Seven Hills 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:

## **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.
      - ◆ The event is one of the following (even if the outcome was not death or major permanent loss of function):

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 3 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED:

- 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 program, or the Safety Committee may assign this responsibility to another member of the committee.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 4 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED:

- **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.
  - Submit the occurrence report to the designated individual or committee per organizational policy.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 5 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED:

- 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 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 #1067
	PAGE: 6 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED:

- 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 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



SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1067
	PAGE: 7 OF: 7
	EFFECTIVE: 1/15/2014
APPROVED BY: Governing Body	REVISED:

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.

## SAFETY REGULATION SURGICAL AREA

1. Prior to beginning of the administration of anesthesia, the anesthesiologist shall check the readiness, availability, and satisfactory working condition of all equipment used in the administration of anesthetic agents. If a leak or any other defect is observed, the equipment must not be used until the defect has been corrected.
2. No explosives or flammable agents shall be used for anesthesia.
3. The analgesia gas machine shall have an oxygen low pressure alarm system and gas scavenging system.
4. It is desirable that use of extension cords be discouraged; however, if they are used, they are to conform to standards.
5. The condition of all operating room equipment is to be inspected regularly and a written record maintained. This is the responsibility of the Director of Nursing.
6. The temperature of the Operating room shall be maintained at 65-68 degrees. F.
7. Humidity shall be maintained at 45-55%.
8. No smoking in the Operating Suite.