

**Steve Sisolak**  
*Governor*



**Richard Whitley**  
*Director*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

**Sentinel Event Registry**

**2019 Annual Sentinel Event Registry Report of  
Submitted Patient Safety Plans**

Healthcare facility submitted patient safety plans (PSP) for 2019.

<https://www.leg.state.nv.us/NRS/NRS-439.html#NRS439Sec843>

and

**NRS 439.865 Patient safety plan: Development; inclusion of infection control program to prevent and control infections; approval; notice; compliance; annual review and update.**

1. Each medical facility that is located within this state shall develop, in consultation with the providers of health care who provide treatment to patients at the medical facility, an internal patient safety plan to improve the health and safety of patients who are treated at that medical facility.

2. The patient safety plan must include, without limitation:

(a) The patient safety checklists and patient safety policies most recently adopted pursuant to [NRS 439.877](#).

(b) An infection control program to prevent and control infections within the medical facility. To carry out the program, the medical facility shall adopt an infection control policy. The policy must consist of:

(1) The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization and the Society for Healthcare Epidemiology of America; and

(2) Facility-specific infection control developed under the supervision of a certified infection preventionist.

3. The program to prevent and control infections within the medical facility must provide for the designation of a person who is responsible for infection control when the infection control officer is absent to ensure that someone is responsible for infection control at all times.

4. A medical facility shall submit its patient safety plan to the governing board of the medical facility for approval in accordance with the requirements of this section.

5. After a medical facility's patient safety plan is approved, the medical facility shall notify all providers of health care who provide treatment to patients at the medical facility of the existence of the plan and of the requirements of the plan. A medical facility shall require compliance with its patient safety plan.

6. The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

(Added to NRS by [2002 Special Session, 15](#); A [2011, 679, 1583](#))

Going forward all Patient Safety Plans will be required to include the facility name and the facility location city. In addition, all Patient Safety Plans must be ADA compliant.



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## **PURPOSE:**

- The purpose of the Organizational Patient Safety Plan at 215 Surgery Center is to improve patient safety and reduce risk to patients through an environment that encourages:
  - Recognition and acknowledgment of risks to patient safety and medical/health care errors;
  - The initiation of actions to reduce these risks;
  - The internal reporting of what has been found and the actions taken;
  - A focus on processes and systems;
  - Minimization of individual blame or retribution for involvement in a medical/health care error;
  - Organizational learning about medical/health care errors;
  - Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations.
- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at 215 Surgery Center. The Patient Safety Plan, developed by the interdisciplinary Safety Committee and approved by the medical staff, Board of Managers and administration, outlines the components of the organizational Patient Safety Program.

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## **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.

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- ◆ The event is one of the following (even if the outcome was not death or major permanent loss of function):
  - Rape (by another patient, visitor or staff)
  - Surgery on the incorrect patient or incorrect body part
- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important facility and patient care functions of:
  - Patient Rights
  - Assessment of Patients
  - Care of Patients
  - Patient/Family Education
  - Continuum of Care
  - Leadership
  - Improving Organization Performance
  - Management of Information
  - Management of Human Resources
  - Surveillance, Prevention and Control of Infection
- Methodology:
  - The Interdisciplinary Safety Committee is responsible for the oversight of the Patient Safety Program. The Safety Officer will have administrative responsibility for the

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program, or the Safety Committee may assign this responsibility to another member of the committee.

- **All departments** within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Safety Officer, who will aggregate occurrence information and present a report to the Safety Committee on a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety Committee will analyze the report information and determine further patient safety activities as appropriate.
- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organizationwide program.
- Upon identification of a medical/health care error, the patient care provider will immediately:
  - Perform necessary healthcare interventions to protect and support the patient's clinical condition.
  - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
  - Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
  - Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.
  - Report the medical/health care error to the staff member's immediate supervisor.

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- Submit the occurrence report to the designated individual or committee per organizational policy.
- Any individual in any department identifying a potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Quality Assurance Committee per organizational policy
- Staff response to medical/health care errors is dependent upon the type of error identified:
  - No harm errors - (including “no harm” medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
  - Mild-Moderate Adverse Outcome Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Performance Improvement Department per organizational policy.
    - ◆ Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Services Department of the event.
  - Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Performance Improvement Department per organizational policy. Staff will also notify the Pharmacy Services Department.
  - Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will

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immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Performance Improvement Department per organizational policy.

- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.
- Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to the Performance Improvement Department.
- Established organizational policy (such as the Sentinel Event Policy) and/or the Safety Committee will determine the organizational response to medical/health care errors and occurrences. All sentinel events and near miss occurrences will have a root cause analysis conducted. The determination of the Safety Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
  - Further remedial action activities necessary for identified occurrences
  - Proactive occurrence reduction activities
  - Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities
- An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Safety Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence
  - Sentinel Events - staff members involved in a sentinel event occurrence will receive support from the Safety Committee regarding the staff member's

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professional and emotional reconciliation of the sentinel event. The Safety Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from his or her department supervisor.

- On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.
- The Patient Safety Program includes a quarterly survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Safety Committee will analyze error reporting data for evidence of this information.
- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care.
- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per facility policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.
- A quarterly patient safety report will be forwarded to the Board of Managers on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.



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### 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

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- 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.

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### 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.

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### **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.

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- Make recommendations to the Governing Body to reduce the number and severity of sentinel events that occur at the facility.
- Assess the quality indicators that affect patient safety and patient health outcomes.
- Coordinate the collection of data from the quality indicators where needed, perform QI studies and improve our patient care processes.

### IV. Definitions

*Incident* - any occurrence that is not consistent with the routine care or operation of the organization. Incidents may involve patients, visitors, employees and medical staff members (i.e. patient fall, employee injury, etc.).

*Adverse Incident/Sentinel event* – Is defined as an unexpected occurrence during a healthcare visit involving, death or serious physical or psychological injury or the risk thereof, including, loss of limb or function, not related to the natural course of the patient’s illness or underlying condition (AAAHC/Nevada Revised Statutes).

*Root Cause Analysis* – Is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special causes in clinical processes to common causes, in organizational processes and systems and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis, that no such improvement opportunities exist. [Joint Commission on Accreditation of Healthcare Organizations]

*Action Plan* – The product of the root cause analysis is an action plan that identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions. [Joint Commission on Accreditation of Healthcare Organizations]

*Near Miss* – any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome. [Joint Commission on Accreditation of Healthcare Organizations] It is an event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or by timely intervention. Near misses are opportunities. Examples of near miss that would require the use of an incident form include but are not limited to:

- Equipment Reprocessing errors not used on patients.

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### 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.

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### *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

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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

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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

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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.

<b>Title: Banner Health System Quality and Safety Plan</b>	
<b>Number:</b> 778, <b>Version:</b> 18	<b>Original Date:</b> 09/19/2002
<b>Effective:</b> 02/12/2020	<b>Last Review/Revision Date:</b> 02/12/2020
<b>Next Review Date:</b> 02/12/2021	<b>Author:</b> Christina Forman-Goerke (Care Management)
<b>Approved by:</b> Banner Health Board of Directors Quality Committee, Administrative Policy Committee, Banner Health Board of Directors, Chief Clinical Officer, Clinical Leadership Team, Harm Avoidance Team, PolicyTech Administrators 02/12/2020	
<b>Discrete Operating Unit/Facility:</b> Banner Baywood Medical Center Banner Behavioral Health Banner Boswell Medical Center Banner Casa Grande Medical Center Banner Churchill Community Hospital Banner Del E Webb Medical Center Banner Desert Medical Center Banner Estrella Medical Center Banner Fort Collins Medical Center Banner Gateway Medical Center Banner Goldfield Medical Center Banner Heart Hospital Banner Ironwood Medical Center Banner Lassen Medical Center Banner Payson Medical Center Banner Thunderbird Medical Center Banner—University Medical Center Phoenix Banner—University Medical Center South Banner—University Medical Center Tucson Community Hospital East Morgan County Hospital McKee Medical Center North Colorado Medical Center Ogallala Community Hospital Page Hospital Platte County Memorial Hospital Sterling Regional MedCenter Washakie Medical Center	<b>Banner Corporate</b>  <b>Ambulatory Services</b> Banner Health Clinics Banner Imaging Services Banner MD Anderson Cancer Center Banner Surgery Centers Banner Urgent Care Centers Occupational Health/Employee Services Rural Health Clinics  <b>Banner Home Care and Hospice (BHCH)</b>  <b>Banner Pharmacy Services</b>  <b>Insurance</b> Banner Health Network Banner Plan Administration University Physicians Health Plans  <b>Post-Acute Care Services (PACS)</b>  <b>Research</b>

## I. Purpose/Population:

- A. The purpose of the Banner Health Quality and Safety Plan is by design to outline Banner Health's commitment and systematic approach to quality and patient safety at all levels of the organization consistent with its Mission, Values, and Purpose. Banner Health's quality goal is to continuously improve and increase reliability of our processes and outcomes for the safety and betterment of our patients and other customers, our providers, our partners, our communities and ourselves.
- B. **Population:** All Employees.
- C. Mission: Making health care easier, so life can be better.
- D. Values:
  - 1. **Customer Obsessed**
    - a. Puts the need of the customer and team at the center of decision making
    - b. Demonstrates empathy and compassion
    - c. Seeks to consistently enhance interactions and experience by exceeding customer and team member expectations
    - d. Thinks creatively about solutions and takes ownership
    - e. Is passionate about exceptional patient care
  - 2. **Relentless Improvement:**
    - a. Takes action that influences and motivates others
    - b. Instills positive energy and builds a shared vision and purpose
    - c. Ensure that the results of the collective effort aligns with objectives and goals
    - d. Uses data to drive streamlined decision making while also considering the impact on our Mission, people and culture
    - e. Effectively utilizes the organization's decision making process and knows when to collaborate, question or empower
  - 3. **Courageously Innovate**
    - a. Identifies opportunities to create value by introducing new ideas and driving change
    - b. Sees possibilities that don't currently exist
    - c. Takes risks and challenges the status quo with the intent to strengthen team and organizational performance
    - d. Leverages knowledge and technology to enrich the patient and team member experience and facilitate speed, simplicity and efficiency
  - 4. **Disciplined Focus**
    - a. Is able to assess what is important, balances priorities and creates a clear and effective plan to drive desired outcomes
    - b. Uses time management effectively and measures progress
    - c. Embodies selflessness by always making the team and our Mission the first priority
    - d. Is constantly learning, adapting and paying attention to details
  - 5. **Foster Accountability**
    - a. Takes responsibility and ownership for work
    - b. Actively resolves problems individually and as part of team
    - c. Addresses performance issues with systems and people as opportunities to achieve excellence
    - d. Recognizes and reinforces success and establishes processes for sustainability
    - e. Maintains a team focus and role models servant-leadership
  - 6. **Continuously Earn Trust**
    - a. Fosters strong and authentic relationships in every interaction by demonstrating honesty, respect and assuming positive intent.
    - b. Actively listens to the needs of others, and follows through on commitments

- c. Creates an open culture of communication that honors the truth and values diverse input

E. Purpose:

1. Banner can and will create a new model that answers America's health care challenges today and in the future.
2. Inspired to change the health care landscape in our communities – big and small – our talented and passionate teams care deeply about individuals who are responsible for the needs of their extended families.
3. Taking access and delivery from complex to easy, from costly to affordable and from unpredictable to reliable, we give every individual we serve confidence in their health care experience and its outcome.

## II. Definitions:

- A. Facility – Any Banner Health hospital, ambulatory surgery center, physician/provider office, home health, hospice, skilled nursing facility, clinic, urgent care center where care is provided which Banner wholly owns or partially owns in which Banner Health is responsible by agreement to provide quality management oversight.
- B. Process Owner – A process owner is an individual responsible for their respective level of business operations. A level of business operation could include a whole Facility, a department or a specific service within a department or across a Facility or the organization.
- C. Process Improvement (PI) – Process Improvement is a series of actions taken to identify, analyze and improve existing processes to meet new goals and objectives.
- D. Quality Management – For the purpose of this plan, "Quality Management" includes activities and/or programs such as Quality Assurance, Quality Improvement, Clinical Process Improvement that are designed and implemented to improve the delivery of care and services.

## III. Policy:

- A. Banner Health bases its decisions on its values and applies the Guiding Principles throughout the organization in its Quality Management Model. (See **Figure 1: Banner Quality and Safety Management Model**)
- B. Quality Authority/Responsibility
  1. Governance.

The Banner Health Board of Directors has the ultimate responsibility and accountability for quality of care and services provided by Banner Health.

    - a. The Care Management and Quality Committee of the Board and the Clinical Leadership Team serve as the oversight bodies for quality management and have the following duties and delegated responsibilities:
      - i. Monitor non-financial measures of organizational quality performance.
      - ii. Ensure use of a systematic approach to quality management and assess ongoing improvement in the quality of services delivered by the corporation.
      - iii. Review and make recommendations to the Board regarding a system-wide quality plan.
      - iv. Evaluate and make recommendations to the Board concerning healthcare technologies including, but not limited to, genomics, biotechnology, future clinical services delivery and therapeutics.

- v. Evaluate and make recommendations to the Board with respect to ethical implications relating to the activities and services of the corporation, including quality and clinical innovation.
    - vi. Review reports regarding the quality of care being provided in respective Facilities.
    - vii. Perform such other duties and responsibilities as the Board may assign to the Committee from time to time.
  - b. The Care Management and Quality Committee and the Medical Staff Subcommittee of the Care Management and Quality Committee serve as the oversight bodies for quality management activities pertaining to the acute care hospital medical staffs and have the following duties and delegated responsibilities.
    - i. Act for the Board with respect to proposals of management and the local institutions and their medical staffs concerning medical staff policies, patient care policies, and compliance with standards of government and accreditation agencies having jurisdiction over the corporation's institutions as to such policies which require the involvement of the Board of Directors.
    - ii. Act for the Board of Directors on matters and activities pertaining to the medical staffs of each local institution operated by the corporation to the extent permitted by law and applicable accreditation standards, including any matter which requires action by the Board of Directors, including the adoption, amendment or repeal of medical staff bylaws, rules and regulations, and medical credentialing criteria.
    - iii. Act for the Board of Directors to the extent permitted by law and applicable accreditation standards, and otherwise make recommendations to the Board of Directors on any matter affecting medical staff membership or privileges, including application for appointment to the medical staff; application for reappointment to a medical staff; request for delineated clinical privileges; and denial, curtailment, limitation or revocation of any of the foregoing.
    - iv. Review reports regarding the quality of care being provided in respective Facilities.
    - v. Perform such other duties and responsibilities as the Board may assign to the Committee from time to time.
  - c. In some communities, Advisory Boards provide advice and counsel to management and medical staff leadership on a variety of issues, including quality and safety activities and outcomes.
- 2. Leadership.
  - a. Leadership is responsible for setting organizational direction and does this through the establishment of mission, values, and purpose, including annual initiatives. These are turned into actions through the development and execution of the strategic and operational plans that include quality of services and patient safety. Senior leadership communicates organizational direction, reviews and approves plans, provides resources and structure for the execution of the plans, and reviews performance to meet the goals of the plan.
  - b. At Banner Health, Care Management provides oversight for improvement of clinical care and patient safety coordinated across the system. The Clinical Leadership Team, a group of Banner Health Leaders representing patient care and supporting functions, makes decisions related to system-wide quality and safety goals and activities to achieve those goals.
  - c. Leadership for Facility activities related to quality of services and patient safety is directed by Facility administrative teams working with leaders under the oversight of

the Quality Council structure. (See **Figure 2: Banner Facility Quality and Safety Structure Template**)

- d. Quality Councils are responsible for the oversight of:
    - i. Quality Leadership:
      - (i) Development and prioritization of Facility quality and patient safety goals and targets in an annual work plan.
      - (ii) Facilitation of ongoing quality and patient safety education
      - (iii) Communication of the quality and patient safety commitment, goals, targets and performance.
      - (iv) Alignment of policies with quality and patient safety commitment.
      - (v) Establishment of an engaged workforce.
    - ii. Quality Management:
      - (i) Identification of patients and other customer needs.
      - (ii) Identification of key processes; standardization and simplification.
      - (iii) Establishment of measures and monitoring.
      - (iv) Assessment and analysis of processes and outcomes.
      - (v) Identification of improvement opportunities.
    - iii. Performance Improvement:
      - (i) Evaluation and prioritization of improvement opportunities.
      - (ii) Identification and replication of proven or evidence-based practices.
      - (iii) Clinical Innovation through the rapid identification and deployment of strategies based on the science of care delivery.
      - (iv) Allocation of resources for improvement.
      - (v) Celebration of success.
    - iv. Evaluation
      - (i) Evaluation of this plan occurs at the local and system levels. Locally, each Facility reviews its progress towards goals identified in the annual work plan using data that measures clinical, financial, resource utilization, and service performance. To assure sustained improvement, this process includes a review of how improvements have been made and will be maintained. Additionally, leaders evaluate their own performance in supporting sustained improvement. Areas failing to meet targets become areas of focused improvement activities. At the system level, performance information is regularly aggregated for review by leadership and governance.
3. Process Owner/Department Managers.
    - a. Process owners, individuals who serve in a leadership role in the performance of a process, are responsible for understanding patient and other customer needs, analyzing the processes used to meet those needs, standardizing and simplifying them to reduce variation and waste, measuring important indicators, and using this data to determine appropriate improvement actions based on the organization's goals.
  4. Employees, Contacted Staff and Volunteers.
    - a. To assure that the organization meets the needs of its patients and other customers as they interact with nursing and other clinical staff as well as support staff, leadership has committed to developing an engaged workforce (staff, contracted staff and volunteers) who:
      - i. Understand job expectations and responsibilities, including service standards;
      - ii. Have access to information to determine if patient and other customer needs are being met and understand how to respond quickly to resolve problems.

- iii. Are provided opportunities and skills for meaningful involvement in improving operations;
  - iv. Recognize the need to work together to meet patient and other customer needs; and
  - v. Know how to identify and report incidents.
5. Medical Staff
- a. Providers fulfill their Medical Staff delegated peer review responsibilities and take a leadership role in quality and patient safety activities. Medical Staff Departments and Committees routinely review clinical performance measures and identify improvement opportunities. Medical Staff leaders partner with administration in the leadership of quality management through routine interaction with administrative leaders and also serve on Quality Councils. In addition, providers serve in various capacities as team members, collaborating with other members of the health care team, to monitor and improve processes.
  - b. The Board of Directors has delegated responsibility for review of professional practices to the medical staffs as set forth in the Medical Staff Bylaws. The Medical Executive Committees report on their performance of these responsibilities to the Board through the Medical Staff Subcommittee of the Care Management and Quality Committee of the Banner Health Board.
6. Risk Management
- a. Risk Management conducts activities intended to improve the quality of care and reduce errors and omissions. Risk Management may report trends and concerns relating to individual physicians and allied health providers to the appropriate Medical Staffs to determine whether peer review is warranted. Risk Management may report other trends and concerns to the appropriate subcommittee of the Clinical Leadership Team.
- C. Quality Management is initiated as leadership sets organizational direction by planning and developing goals, including quality, patient safety and risk priorities that are based on continuous efforts to understand the needs of those we serve as well as improving current levels of performance, utilizing evidence-based and best practices and industry benchmarks. Areas identified for improvement and for achievement of the vision are called strategic initiatives. Strategic and operational planning processes as well as proactive risk assessment and gap analyses are used to identify desired outcomes and actions to achieve those goals at various levels of the organization. Criteria used for establishing priorities may include, but are not limited to, clinical quality, patient safety, customer satisfactions, strategic direction, financial sustainability, regulatory and accreditation compliance, resource utilization, high volume, high risk, or problem prone areas and external forces.
- D. Process owners are expected to identify patient and other customer needs and expectations, understand key processes and safe practices, and establish performance measures for their areas of responsibility. Performance measures encompass different dimensions, including clinical outcomes, patient safety, evidence-based practice, utilization management, and patient satisfaction as well as financial sustainability, and are aligned from the system level (e.g., quarterly patient satisfaction with inpatient care) to the process level (e.g., daily feedback from patients in a nursing unit).
- E. Appropriate improvement action is determined by analyzing and interpreting data over time, utilizing principles of variation. Process owners are responsible for continuously standardizing and simplifying processes to increase reliability through the reduction of variation and waste. They are also responsible for proactively recognizing and



implementing proven or evidence-based practices for existing processes, using current literature sources and benchmarking activities internally as well as externally.

- F. If processes are unstable, process owners investigate and work to remove the cause of the variation. If the variation results in a significant event, it is analyzed and acted on according to policy.
- G. When data indicates a need to identify and correct the root cause of a problem, or there is an opportunity to move to a new level of performance, improvement projects are established. In these cases, teams, formal and informal, apply improvement processes that systematically move through the following five steps:
  - 1. Define the project
  - 2. Measure current performance
  - 3. Analyze to identify causes
  - 4. Improve
  - 5. Control
- H. To assure that the changes required for improvement are successful, the human aspects of change are also addressed using a change model that addresses the need for effective change leadership, creating a shared need, shaping a shared vision, mobilizing commitment, implementing the change monitoring results, and anchoring the change in systems and structure.
- I. Communication of improvement opportunities, new processes or practices are reported up and down the organization through defined reporting structures which include department, Facility and system-wide councils.
- J. When current processes are not able to achieve customer expectations and/or established performance goals, new processes and services are designed and implemented utilizing evidence-based and innovative practices. A systematic approach involves multiple departments and disciplines working collaboratively, using information from patients, staff, payers, and others, along with current comparative information/data from other organizations.
- K. Data for monitoring the effectiveness and safety of services and the quality of care at each Facility, including clinical outcomes, patient safety, evidence-based practice, utilization management and patient satisfaction, are collected and evaluated on an ongoing basis and reported up to governance for recommendations and actions on at least a quarterly basis.
- L. When performance issues may be related to the professional practice of an individual medical staff member, medical staff committees review such professional practices and determine appropriate action, if any.
- M. All proceedings, records, and materials related to Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management and peer review activities are confidential in accordance with federal and state laws. Meetings will be held in confidence and minutes will be maintained separately. Dedicated portals with restricted access will be created to allow the sharing of confidential information.
- N. When performance issues may be related to the performance of a staff member, they will be handled through the appropriate Banner Health Human Resources policies and/or procedures.

- O. New committees and new organization structures may be formed from time to time and the work performed by these groups is intended to be covered under the auspices of the Quality Plan and the protections afforded by federal and state law.

**IV. Procedure/Interventions:**

- A. N/A

**V. Procedural Documentation:**

- A. N/A

**VI. Additional Information:**

- A. N/A

**VII. References:**

- A. Arizona Statutes: A.R.S. § 36-441 et seq. A.R.S. § 36-2401 et seq., A.R.S. § 36-445 et seq.
- B. California Statutes: Cal.Health & Safety Code § 101848.9D.
- C. Colorado Statutes: C.R.S.A. § 25-3-109
- D. Nebraska Statutes: Title 172 NAC, Chapter 5
- E. Nevada Statutes: NRS 439.865
- F. Wyoming Statutes: W.S. 35-2-910
- G. CMS Conditions of Participation
- H. The Joint Commission

**VIII. Other Related Policies/Procedures:**

- A. Banner Health Strategic Initiatives/Plan
- B. Facility Work Plans
- C. [Event Reporting](#) (#911)
- D. [Post Discharge Patient Complaint and Grievance](#) (#1341)
- E. [Peer Review, Medical Staff](#) (#760)

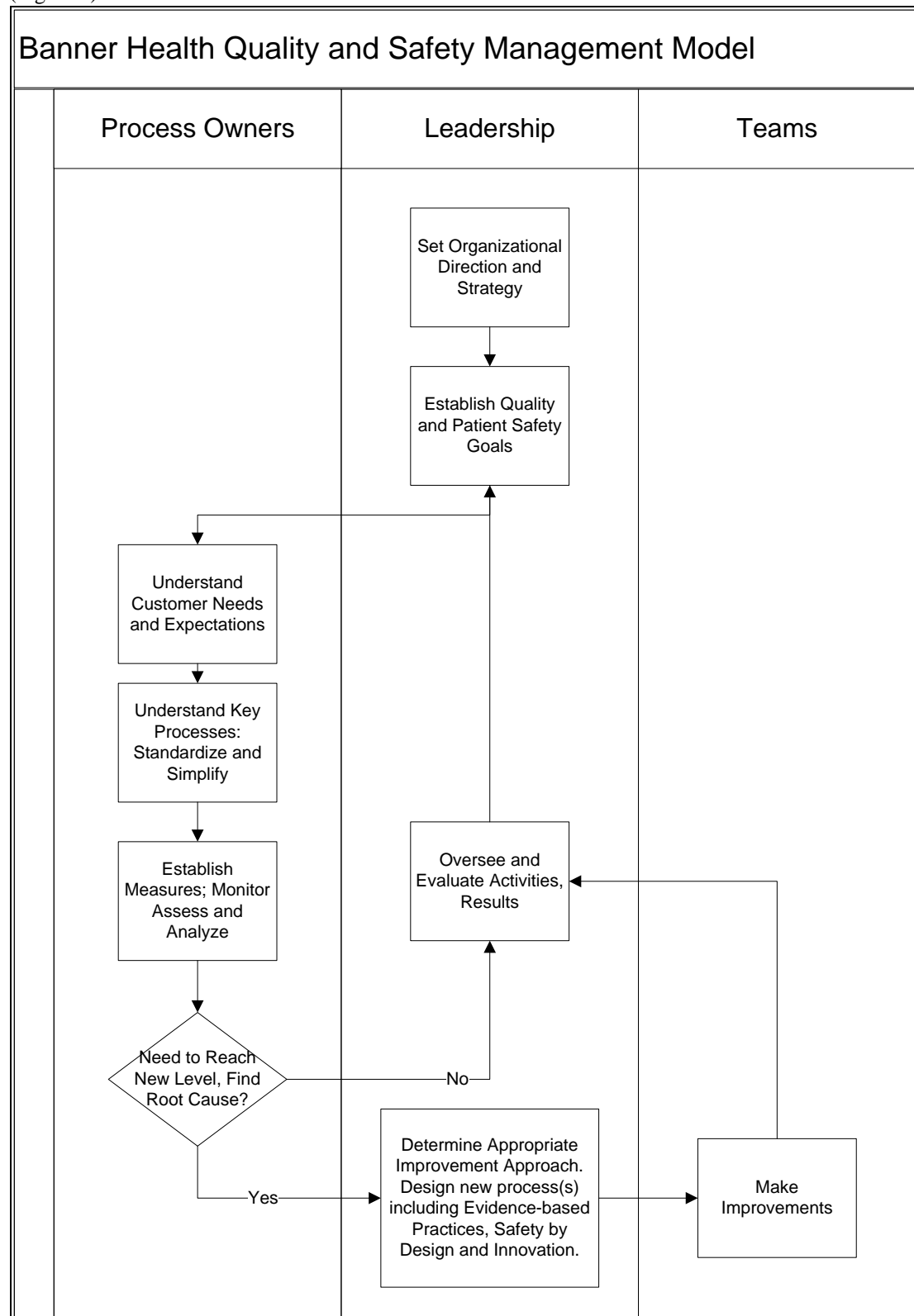
**IX. Keywords and Keyword Phrases:**

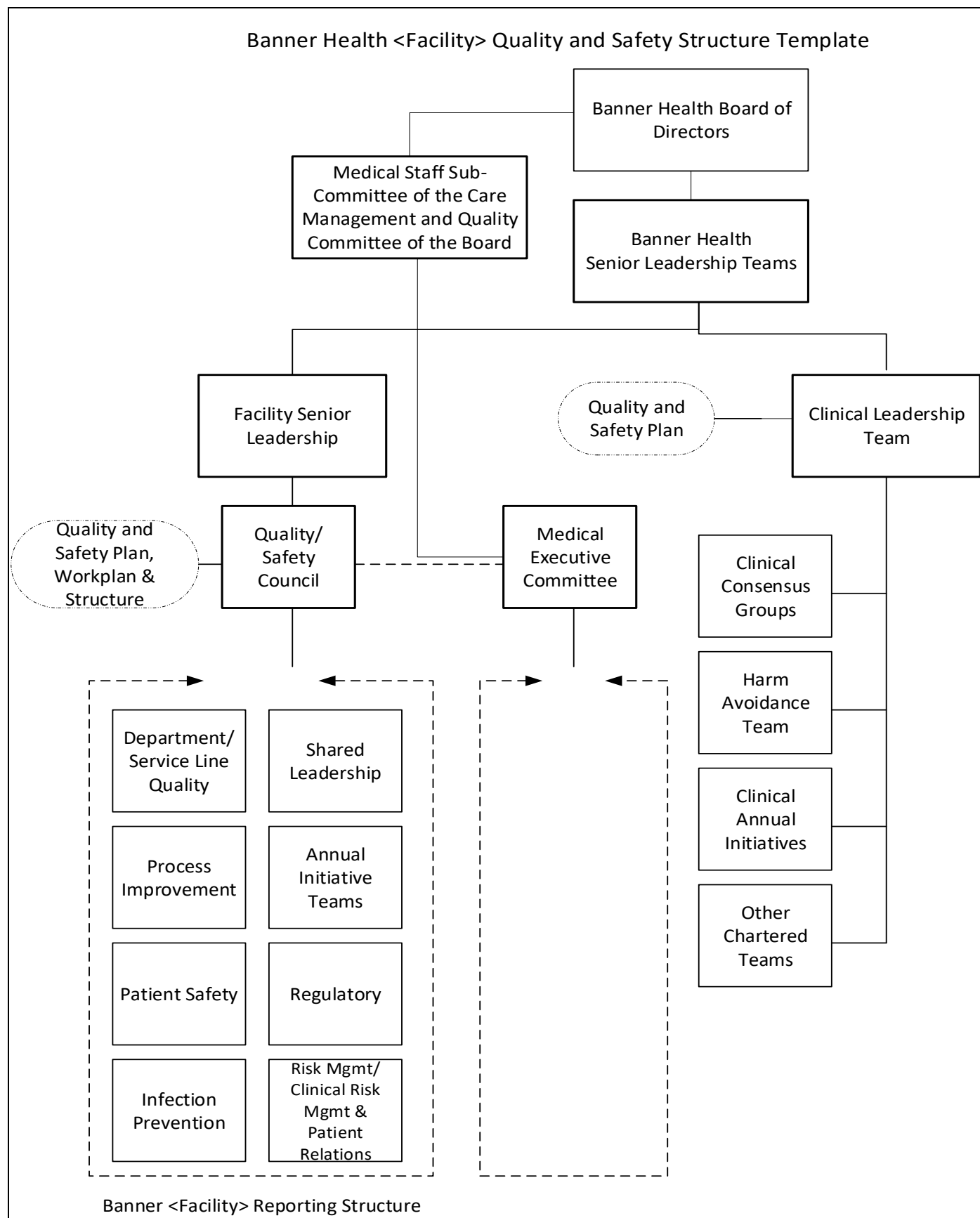
- A. Board
- B. Care Management
- C. Mission
- D. Quality Management
- E. Quality Plan
- F. Vision
- G. Safety Plan
- H. Patient Safety Plan

**X. Appendix:**

- A. Figure 1: Banner Quality and Safety Management Model (See Section III.A: Appendix below)
- B. Figure 2: Banner Facility Quality and Safety Structure Template (See Section III.B.2: Appendix below)

(Figure 1)





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# **Patient Safety Plan**

**2020**

**Barton Health**

**Dan Evans, MS, MA, RPH, CPPS, CPHQ**  
**Director of Patient Safety**

## ***Executive Summary***

The purpose of the Patient Safety Plan is to set the foundation for patient safety at Barton Health in accordance with state and regulatory requirements. The breadth of Patient Safety is vast and includes event reporting, review, follow up on errors and harm that impact or have the potential to impact patients, hazard mitigation through evidence-based tools, and reporting to internal committees and external agencies. The Patient Safety Plan addresses high reliability processes to correct opportunities for improvement and prevent identified hazards from recurrence. 2019 high priorities are reviewed which included: medication safety, labor interruptions, tubing connections, teamwork enhancement through TeamSTEPPS, improving patient handover communication, clinical alarms, hospital survey on patient safety culture analysis, and Just Culture training. 2020 high priorities include: continued assessment of communication in handoffs/hand overs; decreasing alarms, alerts, and notification overload; evaluation and monitoring of staffing needs; the development of a pediatric strategic plan; the Leapfrog Hospital Survey; reassessing staff perceptions of patient safety through the Hospital Survey on Patient Safety; and expanding the current employee support program after serious events. The Patient Safety Plan grants authority for Patient Safety oversight across the organization to the Chief Medical Officer and the Director of Patient Safety. This plan is revised and updated annually or more often as needed.

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## ***Section A***

### ***2020 Patient Safety Plan***



**Purpose**

Barton Health is committed to continuously improving patient safety and reducing health care errors. This Patient Safety Plan ensures that Barton Health implements and maintains a patient safety program in accordance with The Joint Commission standards, guidelines from the California Department of Public Health (CDPH), Nevada Revised Statutes (NRS), Patient Safety and Quality Improvement Act of 2005, and other regulatory agencies.

**Introduction**

The Patient Safety Plan supports and promotes the mission, vision, values, and strategic plan of Barton Health. This Plan implements continuous integration and coordination of patient safety activities for all medical staff, clinical departments, support service departments and service lines including trauma at Barton Health. A culture of safety inherently implies the continued attention, refinement and progression of the patient safety plan and program.

Barton Health's patient safety goal is to foster an environment and culture where patients, families, staff and leaders within the organization identify and manage actual and potential risks to patient safety thereby resulting in zero harm. All patients and staff are strongly encouraged and supported with multiple avenues/programs to speak up when safety concerns are identified. As an organization, Barton Health has the obligation to listen and respond to these concerns.

The Patient Safety Plan is designed to reduce patient safety errors and improve patient care delivery processes by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach centers on the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reductions in health-related errors including near miss and good catch events; and integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions, and services. Patient safety is emphasized in areas such as patient's rights, patient and family education, continuity of care, risk reduction, and managing performance improvement.

Each employee performs a critical role in patient safety and thus, Barton Health's journey to becoming a high reliability organization. All Barton Health team members are focused on providing consistently exceptional care through an environment that supports teamwork, collaboration and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and safety while setting expectations for those who work in the organization. Leadership evaluates the culture of safety on a regular basis.

The Chief Medical Officer and Director of Patient Safety provide oversight to the integrated patient safety program. These individuals ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.

The Director of Patient Safety and Patient Safety Department have the authority to intervene in any clinical or non-clinical activity which poses an actual or potential negative outcome to a patient's well-being. The Patient Safety Department provides leadership in the creation, initiation and evaluation of corrective action measures for event resolution.

The Governing Body, Board Quality Committee, and Patient Safety Committee, described below, are committed to patient safety. These bodies shall assure an environment that encourages error identification, remediation, non-punitive reporting, and prevention through education, system redesign, or process improvement for any potential or actual adverse event.

In accordance with The Joint Commission's Accreditation Participation Requirements, APR.09.02.01, this plan implies Barton Health shall:

- Educate its staff, medical staff, and other individuals who provide care, treatment, and services that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission.
- Inform its staff and medical staff that Barton Health will take no disciplinary or punitive action because an employee, physician, or other individual who provides care, treatment, and services reports safety or quality of care concerns to The Joint Commission.
- Take no disciplinary or punitive action against employees, physicians, or other individuals who provide care, treatment, and services when they report safety or quality of care concerns to The Joint Commission.

Any employee or medical staff member may contact The Joint Commission if they have a safety or quality of care concern that is not being addressed by Barton Health. All employees or medical staff members are strongly encouraged to bring any safety or quality of care concerns to the Chief Medical Officer, Director of Patient Safety, Patient Safety Team members, or Director of Quality without fear of punitive or disciplinary action.

In addition, patients are provided information in the patient handbook regarding their right to contact and report a complaint to The Joint Commission.

### ***Scope of the Patient Safety Plan***

The Joint Commission, CDPH, NRS, Centers for Medicare and Medicaid Services (CMS) and other regulatory agencies provide the defining framework for patient safety events. The Patient Safety Department is informed of safety event information and hazardous conditions from team members, volunteers, and medical staff practitioners across the organization through completion of event reports and verbal or written communication. This information includes actual or potential (near miss/good catch) occurrences involving inpatients, outpatients, volunteers, employees, physicians, allied healthcare providers, vendors, and visitors.

### ***Risk Assessment***

Proactive assessment of high-risk activities and hazardous conditions are identified through event reporting, failure mode and effect analysis (FMEA), data collection, audits (tracers), and utilization. In addition, risk reduction strategies are built into the continual process improvement system. Such strategies are obtained from available information regarding sentinel events known to occur in healthcare organizations that provide similar care and services as well as knowledge-based information including content from state patient safety organizations as well as other state, national, and international professional organizations.

### ***Event Prioritization***

Opportunities for improving patient safety issues are prioritized according to level of severity, frequency of the occurrence, potential for harm to the patient, employee or visitor involvement, and potential for liability. Ongoing review of information is performed to direct administrative and medical staffs' attention to areas of clinical care representing significant sources of actual or potential risk.

Types of medical / health care errors include, but are not limited to:

- **Adverse Event:** Per The Joint Commission, an adverse event is a patient safety event that resulted in harm to a patient. It is also defined as an unexpected occurrence meeting any of the Adverse Event criteria as designated by CDPH.
- **Error:** An unintended omission or commission of an act, or an act that does not achieve its intended outcome.
- **Good Catch/Close Call/Near Miss:** Any patient safety event that did not reach the patient.
- **No-Harm Event:** A patient safety event that reached the patient but did not cause harm.

- **Hazardous Condition:** Any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which increases the probability of an adverse event.
- **Never Event/Serious Reportable Event (SRE):** An event or situation that should never occur in a healthcare facility. When Never Events occur, actions are taken to ensure compliance with the Never Event Policy which includes key steps be completed such as disclosure, apologizing, analysis, and reporting.
- **Sentinel Event:** A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm (Refer to *Sentinel Event* section below) and is reported to The Joint Commission. For Lake Tahoe Surgery Center, located in Nevada, a sentinel event is defined in NRS 439.830 by the National Quality Forum. (Refer to Appendix A).
- **Healthcare Associated Infection (HAI):** A localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) as defined by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) in addition to monthly submission of all surgical site infections associated with different procedures performed at Barton Health. Potential HAIs are reviewed by the HAI Review Committee. Confirmed HAIs are reported to the Patient Safety Committee. HAIs are also reported to the Infection Control and Prevention Committee and Board Quality Committee.

Any patient safety event, incident, or condition that could have resulted or did result in harm to a patient shall be subject for review and further analysis.

### ***Event Reporting***

Identification and reporting of adverse events, including those that result from practitioner error are critical to Barton Health's efforts to continuously improve patient safety and reduce harm. To support and encourage this culture of safety, reporting of patient safety events or near misses is highly encouraged. Reporting of events is the responsibility of all employees, volunteers, practitioners, patients, visitors and guests. Events can be reported through many modalities including electronic, verbal, and written communication. Electronic event reporting is available on all Barton Health System computer terminals. An event is reported via the electronic safety learning system/event reporting system by the individual(s) involved with and most knowledgeable about the event. (Refer to Barton Health Organizational Event Reporting Policy.)

Events are reviewed on a daily basis. High severity events are reviewed promptly to ensure immediate action is taken as warranted.

### ***Regulatory Agency Reporting***

Barton Health informs accrediting and licensing bodies when errors and events fall within that agency's reporting requirements. Team members involved in sentinel or adverse events have access to support and are included whenever possible in the root cause analysis process to ensure the potential for recurrence is minimized.

Intensive assessment may be initiated when undesirable patterns or trends are identified or serious, adverse, or sentinel events occur. This includes those events identified as unusual occurrences within the California Code of Regulations section 76551. Sentinel Events reportable to The Joint Commission and Adverse Events reportable to CDPH are delineated below. (Refer to Appendix A for Nevada Sentinel Event reporting.)

### ***Sentinel Event***

Patient safety events are determined to fall into the category of a Sentinel Event as defined by The Joint Commission when any of the following occur:

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm\*

Or

The event is one of the following (even if the outcome was not death, or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):

- Suicide of any patient receiving care, treatment and services in a staffed around the clock care setting or within 72 hours of discharge including from the hospital's emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including ED), leading to death, permanent harm, or severe temporary harm to the patient
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the organization
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while on site at the organization
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery after the completion of final skin closure
- Severe neonatal hyperbilirubinemia (bilirubin greater than 30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field or any delivery of radiotherapy to the wrong body region or greater than 25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care
- Any intrapartum (related to the birth process) maternal death
- Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm from the intrapartum through postpartum period (24 hours) requiring the transfusion of 4 or more units of packed red blood cells and/or admission to the ICU

\*Severe temporary harm is critical, potentially life threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

It is Barton Health's policy to voluntarily report Sentinel Events to The Joint Commission within their required reporting timeframe (Refer to Barton Health Sentinel Event Policy).

*Adverse Event*

Barton Health shall report an adverse event as defined within Health and Safety Code §1279.1 (below) to CDPH no later than five calendar days after the event has been detected or, if the event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, no later than 24 hours after the adverse event has been detected. Events are investigated, mitigation actions initiated, and cooperation with CDPH occurs throughout the process. (Refer to Barton Health Adverse Event policy)

"Adverse event" includes *any* of the following:

1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.
6. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
9. An infant discharged to the wrong person.
10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.
11. A patient suicide or attempted suicide resulting in serious disability due to patient actions after admission, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.
12. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
13. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

17. A Stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
18. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.
19. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
21. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
22. A patient death associated with a fall while being cared for in a health facility.
23. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
25. The abduction of a patient of any age.
26. The sexual assault on a patient within or on the grounds of the facility.
27. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.
28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

#### *Never Events/Serious Reportable Events*

Barton Health reports Never Events/SREs to the appropriate agency based on the circumstances of the event and criteria met of the regulatory agencies (e.g., CDPH and/or The Joint Commission). Never Events/ SREs include:

#### 1. Surgical or Invasive Procedure Events

- 1A. Surgery or other invasive procedure performed on the wrong site.
- 1B. Surgery or other invasive procedure performed on the wrong patient.
- 1C. Wrong surgical or other invasive procedure performed on a patient.
- 1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
- 1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient.

#### 2. Product or Device Events

- 2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.
- 2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
- 2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.

#### 3. Patient Protection Events

- 3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
- 3B. Patient death or serious injury associated with patient elopement (disappearance).
- 3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.

#### 4. Care Management Events

- 4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
- 4B. Patient death or serious injury associated with unsafe administration of blood products.
- 4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in

a healthcare setting.

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting.

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting.

4G. Artificial insemination with the wrong donor sperm or wrong egg.

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

#### 5. Environmental Events

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting.

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances.

5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting.

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

#### 6. Radiologic Events

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

#### 7. Potential Criminal Events

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.

7B. Abduction of a patient/resident of any age.

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.

7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

#### *Provider-Preventable Conditions*

Federal law requires Provider-Preventable Conditions (PPCs) that occur during treatment of Medi-Cal and Medicaid patients be reported. These include both healthcare-acquired conditions (HCAC) and other provider-preventable conditions (OPPC). California HCACs and OPPCs are reported to the Department of Health Care Services after discovery and confirmation that the patient is a Medi-Cal beneficiary. Nevada HCACs are reported through the Nevada sentinel event registry.

HCACs are defined as:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
  - Diabetic ketoacidosis
  - Nonketotic hyperosmolar coma
  - Hypoglycemic coma
  - Secondary diabetes with ketoacidosis
  - Secondary diabetes with 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
- Deep vein thrombosis (DVT)/ pulmonary embolism (PE) excluding pregnant women and children under 21 years of age

OPPCs are also known as “never events” and Serious Reportable Events under Medicare. For Medi-Cal, OPPCs are defined as:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Providers must report these three OPPCs when these occur in any health care setting. “Invasive procedure” refers to a surgical procedure.

### ***Patient Safety Organization Reporting***

Barton Healthcare System is a member of the California Hospital Patient Safety Organization (CHPSO), which serves as its Patient Safety Organization. Patient Safety Work Product is submitted to CHPSO in accordance with the Patient Safety and Quality Improvement Act of 2005. (Refer to Patient Safety Evaluation System Policy for further details.)

### ***Investigation: Root Cause Analysis, Common Cause Analysis, and Process Improvements***

In any event when an adverse/sentinel event or hazardous condition has occurred, the issue is revisited and the status mitigated through a risk reduction strategy using the Root Cause Analysis (RCA) process. Lesser events are managed through either an RCA or Process Improvement (PI). Reportable Adverse or Sentinel Events shall be subject to an immediate in-depth RCA.

RCAs shall be convened by the Director of Patient Safety or designee and includes team members either directly or indirectly involved in the event. Members from uninvolved departments may be invited to provide additional information. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting the RCA. The Root Cause Analysis and Action Plan Framework Table, introduced by The Joint Commission, contains 24 analysis questions that guide the organization through the steps in a root cause analysis. Not all the questions apply to all the events or cases. The 5 Whys technique is utilized to explore the cause and effect relationship underlay a problem. Root causes can be identified by asking “why” no less than five times. During the RCA, events are deconstructed in an effort to identify the key causes that may have contributed to the event. The deconstruction process leads to action items designed to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors. The Veterans Affairs National Center for Patient Safety Action Hierarchy is used to assure strong corrective action items are identified.

Common Cause Analysis (CCA) is performed when multiple events are aggregated to identify commonalities among the causes. Such analysis permits identification of the breadth and depth of vulnerabilities within the system.

Process Improvement teams are formed when an issue affecting more than one service line is identified and a near miss may or may not be involved. There may be no adverse patient outcome in connection with the event, however, the potential for a patient event should the issue recur is likely. PIs may also result from discussions during RCAs where a system improvement process is identified as a result of a patient event. Team members convene and identify key factors involved in the process through deconstruction that may have contributed to the situation and create action items to



mitigate the identified issues.

RCA and PI workgroups construct action items and assign them to appropriate individuals for completion. Providers and staff involvement is considered essential, since they are the team members on the front line with the most knowledge of the actual day-to-day workings of the processes. Individuals assigned action items are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

As a learning organization utilizing Just Culture, Barton Health focuses on systems and processes, not individuals, during RCA or PI event review.

### ***Disclosure***

Full disclosure of serious medical errors, reportable events and any unanticipated outcomes are communicated to patients/families by the practitioner with the assistance of the Risk Manager, Director of Patient Safety, Patient Safety Officer, Patient Safety Specialist RN, or designee as appropriate. (Refer to Barton Health Disclosure of Unanticipated Outcome Policy and the Never Event Policy.)

### ***Patient Safety Committee***

The Patient Safety Committee is a multidisciplinary team focused on review and discussion of patient events resulting in a near-miss or an untoward outcome as well as process improvements for the purposes of improving patient safety and the quality of care delivered to Barton Health's patients.

The Patient Safety Committee is a standing committee of the Medical Staff. The committee's membership is delineated in Barton Health's Medical Staff Rules.

The Patient Safety Committee shall review and discuss serious patient events, reportable adverse event and sentinel events, HAIs, mortality rates, Sentinel Event Alerts, and systems issues identified by peer review processes. 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, CCA, and PI workgroup recommendations which ultimately minimize the recurrence of comparable patient events or near misses. Recommendations can be revised, added or deleted through this committee.

The Lake Tahoe Surgery Center Patient Safety Committee is a subcommittee of, and reports to, the Patient Safety Committee. Refer to Appendix A.

Department Directors or designees are active participants who complete assigned action items within an appropriate timeframe designated by the work group, Director of Patient Safety, Patient Safety Officer, Patient Safety Specialist RN, Chief Medical Officer, or Patient Safety Committee. Directors are responsible for implementing action items and reporting back to the Patient Safety Committee and/or the Patient Safety Department with status updates and upon completion of assigned action items. Directors are responsible to ensure continued compliance exists with their direct reports and implemented process changes are sustained.

Events and PIs shall be closed through the Patient Safety Committee when all assigned action items have been

completed, any associated audits exhibit compliance, and all remaining concerns are addressed.

The Director of Patient Safety or designee shall report patient safety events and process improvements from the Patient Safety Committee to the Board Quality Committee. The Chief Medical Officer or designee shall report acute events and process improvements from the Patient Safety Committee to the Medical Executive Committee and Governing Board.

### ***Patient Safety Risk Reduction***

Several approaches are utilized at Barton Health to reduce the risk of a patient safety event. The Joint Commission's National Patient Safety Goals, National Healthcare Safety Network (NHSN), Institute for Healthcare Improvement (IHI), Agency for Healthcare Research and Quality (AHRQ), National Patient Safety Foundation, and California Hospital Patient Safety Organization (CHPSO) are some examples of utilized resources to prevent and reduce the likelihood of serious patient safety events. Sentinel Event Alerts released through The Joint Commission are also analyzed for compliance.

### ***National Patient Safety Goals***

Compliance with The Joint Commission's National Patient Safety Goals are monitored and evaluated on a continual basis through observational audits. Data analyses of these audits shall be reported to and reviewed by Board Quality Committee on a biannual basis. Measure of success for compliance on each standard's requirement is expected to be 100% (one hundred percent). Elements below 100% (one hundred percent) are addressed by the appropriate Department Director/Manager. The Director/Manager shall formulate an action plan with the goal of improving the affected element score within their department.

Patient Safety observational audits (tracers) are conducted on a routine basis. Immediate training is provided to staff when non-compliance with policy elements is observed. (Refer to Patient Safety Observational Tracer Policy.)

### ***Sentinel Event Alerts***

Sentinel Event Alerts, published through The Joint Commission, are communicated through the Patient Safety Committee. Compliance status and opportunities for improvement are addressed through workgroups consisting of affected Department Directors/Managers, Executive Team Members and others as appropriate to formulate risk reduction strategies and follow up through an action plan. Action items within the action plan are assigned to individuals who are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

### ***Scientific Model Integration***

The patient safety program has been developed with scientific knowledge in a foundational aspect including concepts from:

- James T. Reason's Swiss Cheese Model of Accident Causation
- Shewhart cycle or Model for Improvement (Plan, Do, Study, Act –PDSA)
- Failure Mode and Effects Analysis (FMEA) or Failure Mode, Effects and Criticality Analysis (FMECA)
- 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.)

- RCA<sup>2</sup>: Improving Root Cause Analyses and Actions to Prevent Harm
- Process Improvement such as Lean and Six Sigma concepts
- Evidence-based practice and clinical practice guidelines

### ***Educational Enhancement Activities***

The Patient Safety Plan provides the opportunity to reduce patient safety events and hazardous conditions through education, proper and effective orientation, and annual training. Barton Health's clinical orientation program emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing patient safety training for Barton Health team members including practitioners is offered through various teaching strategies including, but not limited to, bulletin boards, online learning formats, skills labs, and didactic experiences. Program content may include education specific to patient safety related events or advancements in patient safety practice. As appropriate, this training incorporates methods of team training such as TeamSTEPPS by the American Hospital Association to foster an interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and mechanisms to report patient safety concerns.

### ***Patient Safety Evaluation***

Annually, patient safety activities shall be reviewed and presented to the Patient Safety and Board Quality Committees.

### ***Patient Safety Plan Approval, Revision, and Review***

The Patient Safety Committee shall review and approve this plan at least once a year, but more often as necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices. The Board Quality Committee shall review and approve this plan at least annually.

### ***Authority***

The authority to implement the Patient Safety Plan rests with Barton Health's Governing Body, Board Quality Committee, Medical Executive Committee, and Patient Safety Committee.

### ***Approval***

This plan was approved by the following committees:

Patient Safety Committee on 12/11/2019

Board Quality Committee on 1/2/2020

***Section B:***

***2019 Patient Safety Priority Evaluation***

In 2019, Barton Health's high priorities for Patient Safety included reducing medication errors across the organization, labor interruptions, tubing connections, teamwork enhancement through TeamSTEPPS, assessing communication in handoffs/hand overs, and clinical alarms.

2019 brought a focus on medication safety from a multidisciplinary perspective and improved efficiencies across the healthcare organization. While some new processes were deferred until the new Pyxis upgrade is implemented in the second quarter of 2020, many other opportunities were addressed. A renewed focus on basic principles including the five rights of medication administration, dual sign off and waste witnessing of high-risk medications, and aseptic technique were discussed with staff who are involved in these processes during annual competencies. The outpatient setting received education on intramuscular versus subcutaneous injection sites for pediatrics. Barcode scanning data during refill of the Pyxis units by Pharmacy team members are now reviewed regularly to ensure compliance. A barcode scanning report showing compliance upon medication administration to patients is now automated and sent to all nursing area managers for review on a monthly basis. To ensure compliance with Leapfrog Hospital Safety Survey requirements, the barcode scanning compliance rate was increased to 95% from 90% for medication administration. Finally, the Medication Safety Committee is now reviewing data obtained from the IV pump Dose Evaluation Reference Software to ensure compliance with the utilization of smart pump programming features to increase patient safety during IV administration to patients.

In 2019, a robust plan focused on clinical labor interruptions was developed by the Executive Team and key stakeholders. The plan minimized service disruption and addressed numerous processes ensuring a continuous, high quality patient experience. The formulation of this plan assisted in supporting safety programs while mitigating potential errors and patient harm within the healthcare organization. The plan was successfully implemented twice in 2019, once in May and a second time in September.

The Fall Prevention Workgroup continued in 2019 with the goal of reducing falls across the organization. A workgroup of frontline team members continued to work on fall reduction across the organization and implemented evidence-based fall prevention strategies including the conversion to the Hester-Davis fall risk assessment, use of floor mats, and assessing the need for renting low beds for patients and residents. Post fall huddle forms were integrated into the safety learning system/event reporting system to facilitate ease of use for staff. The group continues to focus on falls with injury and analyzed trends of why they occurred and compare them to the Collaborative Alliance for Nursing Outcomes (CALNOC) database. In 2020, Barton Health will be transitioning to the National Database on Nursing Quality Indicators (NDNQI) who purchased CALNOC. The workgroup will continue to work on implementing evidence-based fall prevention strategies in 2020.

Tubing misconnections were addressed by converting enteral products to meet new standards, and continually monitoring for ISO tubing product changes in accordance with California AB 1867, Joint Commission Sentinel Event Alert 53, and California Health and Safety Code 1279.7. In 2019, healthcare facilities including Barton Health remained awaiting the manufacture and distribution of neuraxial (NRFit®) tubing and syringes. Barton Health proactively communicated with vendors to ensure situational awareness around this product line change. At the end of 2019, a few vendors were beginning to release updated NRFit® products. Collaboration with Supply Chain Management will remain ongoing in 2020 and product transitions will occur with key stakeholder involvement.

TeamSTEPPS tools were introduced to remaining outpatient clinical departments that did not receive training in 2018. Departments were trained on the brief, huddle, and debrief tools and use these tools at the beginning, middle, and end of shifts respectively. These tools have been integrated into new hire clinical orientation to ensure program sustainment. System wide Daily Safety Briefs (DSBs), which are intended to increase safety awareness and enhance communication among interdepartmental teams in addition to supporting Barton Health's journey to becoming a high reliability organization, remained effective during 2019. The introduction of a weekly DSB recap email commenced in

early 2019. The program continues to be well received and highly successful. TeamSTEPPS Master Trainers will continue to integrate additional tools from the program into departments based upon readiness and need in 2020 and beyond.

Clinical alarms as related to NPSG.06.01.01 resulted in ongoing review with heightened attention focused on reducing nuisance/false alarms. To mitigate nuisance alarms, central monitor parameter settings for the pediatric population in the Emergency Department and Intensive Care Unit were adjusted with key stakeholder input to reduce false alarm burden for staff. The modifications resulted in no harm to this patient population. Bedside capnography monitoring continued to be a high priority for the organization with data analytics from the vendor being reviewed to reduce the number of false alarms. Data analytics on clinical alarms will continue to be reviewed and assessed in 2020 for further system optimization.

An FMEA on communication handoffs/handovers commenced in the second half of 2018 and continued throughout 2019. This multidisciplinary workgroup with frontline staff from clinical departments within the acute care setting focused on integrating evidence-based best practices in accordance with The Joint Commission's Sentinel Event Alert 58. Interdisciplinary department members selected a communication issue to work on based on their department's concerns with the goal of improving standardized communication among team members during handoff/handover of patients. Project examples include the standardization of bedside shift report on the second floor, PACU report to second floor staff, shift and break handovers in the OR, picking up and returning patients to the Emergency Department for diagnostic studies in the Medical Imaging department, and report to second floor and Emergency Department staff after a GI lab add on case is performed. The FMEA workgroup will continue their work into 2020.

Barton Health was one of a handful of healthcare organizations who participated in a study for AHRQ related to validating the reliability of new questions in their Hospital Survey on Patient Safety version 2.0 in late 2018. Results were received late in the second quarter of 2019 from the agency who oversaw the survey. The results were segregated into the two groups participants were randomly placed. The analysis of these combined results was shared with Executive Team members. The decision was made to hold off on disseminating these results and to administer the updated version to hospital-based team members in early 2020.

Finally, in order to move forward Barton Health's high reliability journey, Just Culture program education with all providers and staff members occurred during 2019 with over 95% being trained in the first half of the year. To ensure program sustainment, Just Culture training was integrated into new hire orientation.

## ***Section C:***

### ***2020 Patient Safety Priorities***

The Patient Safety Plan identifies and defines goals and specific objectives to be accomplished each year. In 2020, Barton Health's high priorities for Patient Safety include tubing connections; , continued assessment of communication in handoffs/hand overs; decreasing alarms, alerts, and notification overload; evaluation and monitoring of staffing needs; the development of a strategic plan focused on pediatric patients; the Leapfrog Hospital Survey, reassessing staff perceptions of patient safety through the Hospital Survey on Patient Safety; and expanding the current employee support program after serious events.

Measures to prevent adverse events associated with misconnecting intravenous, enteral feeding, and epidural lines will remain a priority in 2020. A complete conversion to the new ISO standard enteral feeding lines occurred in 2015. Manufacturers continue to distribute tubing that can be mistakenly interconnected. However, until connectors are reengineered, approved by the ISO and the FDA, and distributed throughout the healthcare industry, there remains the possibility of human error that can lead to patient harm. Barton Health proactively addresses prevention of adverse events associated with misconnecting IV, enteral and epidural lines through product purchasing and assessment of availability of connectors throughout the organization as well as staff education and awareness. As described in the 2019 priority evaluation, neuraxial (NRFit®) connectors with redesigned incompatible connectors will be transitioned in 2020 as the product line becomes available to ensure compliance with California state law.

The communication FMEA will continue within the organization to ensure best practices are implemented in accordance with The Joint Commission's Sentinel Event Alert 58. The overall goal will be to enhance patient handoff/handover communication among team members. As discussed in the 2019 Priority evaluation, this FMEA will continue into 2020. Upon closure of this FMEA, a new FMEA or FMECA will commence with topic selection based upon collaborative leadership agreement.

Alarms, alerts, and notification overload has been identified as an Emergency Care Research Institute (ECRI) top ten technology priority in 2020. The burden from alarms, alerts, and notifications from medical and communication devices as well as health information technology systems combined can lead to staff fatigue and increases the potential for an immediate response to a clinically significant event to be delayed or go unaddressed. In concert with this concern, the prioritization of NPSG.06.01.01 focusing on clinical alarm system safety will remain a high priority for Barton Health..

In accordance with SB 227, which amends section 1279 of the California Health and Safety Code and goes into effect on January 1, 2020, Barton Health will evaluate and monitor for appropriate staffing levels to ensure all patient care needs are met. This includes staffing levels and competencies for any new patient population that may present to Barton Health.

A strategic plan for providing pediatric care in the inpatient setting will be developed in 2020. This plan, with multi-disciplinary and collaborative input, will focus on several aspects involved in high quality care including pediatric safety. staffing, admission guidelines, clinical competencies, and ongoing education to ensure this patient population's needs are met.

The Leapfrog Hospital Survey will be evaluated in 2020 with the goal of submitting survey responses to ensure inclusion in the fall 2020 Hospital Safety Grade. Assessment, analysis, and submission recommendations for each of the survey's sections will be completed with key stakeholder involvement. Two specific elements of the Leapfrog Hospital Survey, discussed below, related to the Hospital Survey on Patient Safety Culture and staff support program will receive special emphasis in 2020.

The AHRQ Hospital Survey on Patient Safety Culture version 2.0 provides information related to several domains that impact patient safety as well as measuring conditions that can lead to adverse events and patient harm. Barton Health will administer this updated survey in conjunction with Patient Safety Week in March with the intent of measuring any change within the acute care setting since Just Culture training was completed. Based on the findings, action plans may focus on enhancing staff awareness about patient safety, identifying strengths and opportunities for improvement,



evaluating trends in culture changes, and assessing the impact of patient safety initiatives and interventions.

Finally, in 2020 Barton Health will engage in developing a comprehensive staff support program focused on enhancing peer intervention for second victims defined as, "...a healthcare provider involved in an unanticipated adverse patient event, medical error and/or a patient-related injury who become victimized in the sense that the provider is traumatized by the event..." (Scott et al., 2010). Presently, the employee assistance program (EAP) and Critical Incident Stress Management (CISM) debriefs are in place. However, opportunity exists to enhance and expand CISM and to add a peer intervention component. Combined, these elements will ensure a comprehensive organizational-wide program that supports staff resiliency and recovery from events.

## References

- Agency for Healthcare Research and Quality. (2014). *The patient safety and quality improvement act of 2005*. Retrieved from <http://www.ahrq.gov/policymakers/psoact.html>
- California Department of Public Health. (2009, November 19). *AFL 09-41 Health facility connection port prohibitions*. HSC 1279.7. Retrieved from <http://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-09-41.pdf>
- California Department of Public Health. (n.d.) *HSC Code § 1279.1*. Retrieved from [https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=1279.1.&lawCode=HSC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1279.1.&lawCode=HSC)
- [C](#)
- California Department of Public Health (n.d.). *HSC Code § 1279.6*. Retrieved 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 from <http://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-1279-7.html>
- California Department of Health Care Services. (n.d.). *Provider-preventable conditions- definitions*. Retrieved from [https://www.dhcs.ca.gov/individuals/Pages/PPC\\_Definitions.aspx](https://www.dhcs.ca.gov/individuals/Pages/PPC_Definitions.aspx)
- California Department of Public Health. (2018). *Reportable adverse events*. Retrieved from <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Reportable-Adverse-Events.aspx>
- Centers for Disease Control and Prevention's National Healthcare Safety Network. (2018). *Healthcare-associated infections (HAIs)*. Retrieved from <http://www.cdc.gov/hai/>
- ECRI Institute. (2019). *Top 10 health technology hazards for 2020*. Retrieved from <https://www.ecri.org/landing-2020-top-ten-health-technology-hazards>
- Elliott, M., Page, K., & Worrall-Carter, L. (2012, December). Reason's accident causation model: Application to adverse events in acute care. *Contemporary nurse: A journal for the Australian nursing profession*, 43(1):22-8.
- GEDSA. (2018). Neuraxial connectors NRFit® overview of design changes. *Stay connected*. Retrieved from

<http://stayconnected.org/neuraxial-nrfit/>

McGinley, P. (2010, May/June). *Common Cause Analysis*. Patient Safety & Quality Healthcare. Retrieved from

<https://www.psqh.com/analysis/common-cause-analysis/>

National Quality Forum. (2019). *List of SREs*. Retrieved from

[http://www.qualityforum.org/Topics/SREs/List\\_of\\_SREs.aspx](http://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx)

Nevada Division of Public and Behavioral Health (2019, July 312015). Sentinel event registry. Retrieved

from [http://dpbh.nv.gov/Programs/SER/Sentinel\\_Events\\_Registry\\_\(SER\)-Home/](http://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_(SER)-Home/)

Nevada Revised Statutes. Health and safety of patient at certain medical facilities. NRS

439.800-439.890

Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M., Hahn-Cover, K., Epperly, K. M.,... Hall, L. W. (2010). Caring for our

own: Deploying a systemwide second victim rapid response team. *The Joint Commission Journal on Quality and Patient Safety*, 36(5). Retrieved from

<https://medschool.ucsd.edu/som/hear/resources/Documents/caring%20for%20our%20oenScott-JCJQPS-2010-ID-18023.pdf>

The Joint Commission Standard APR.09.02.01

The Joint Commission Standard LD.04.04.05

The Joint Commission. (2019). *2020 National Patient Safety Goals*. Retrieved from

[http://www.jointcommission.org/standards\\_information/npsgs.aspx](http://www.jointcommission.org/standards_information/npsgs.aspx)

The Joint Commission. (2017). *Sentinel event alert 58: Inadequate hand-off communication*. Retrieved from

[https://www.jointcommission.org/sentinel\\_event\\_alert\\_58\\_inadequate\\_handoff\\_communications/](https://www.jointcommission.org/sentinel_event_alert_58_inadequate_handoff_communications/)

The Joint Commission. (2019, August 8 ). *Sentinel event policy and procedures*. Retrieved from

[https://www.jointcommission.org/sentinel\\_event\\_policy\\_and\\_procedures/](https://www.jointcommission.org/sentinel_event_policy_and_procedures/)

Thomson Reuters. (2017). *\$76551. Unusual occurrences*. Retrieved from

[https://govt.westlaw.com/calregs/Document/I2C5D4330FB1811DEACA9F33E9EE53480?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/I2C5D4330FB1811DEACA9F33E9EE53480?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default))

U. S. Department of Veterans Affairs. (2015). *Root cause analysis tools*. Retrieved from

[http://www.patientsafety.va.gov/docs/joe/rca\\_tools\\_2\\_15.pdf](http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf)

***Appendix A:***

***2020 Lake Tahoe Surgery Center  
Patient Safety Plan***

This plan was created and revised by the Lake Tahoe Surgery Center Patient Safety Committee, a subcommittee of Barton Health's Patient Safety Committee. Implementation of this plan is intended to optimize healthcare patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events. This Patient Safety Plan ensures that Barton Health implements and maintains a patient safety program in accordance with The Joint Commission standards, Nevada Revised Statutes (NRS), Patient Safety and Quality Improvement Act of 2005, and other regulatory agencies.

**Patient Safety Plan**  
**Lake Tahoe Surgery Center**  
212 Elks Point Road, Suite #201  
Zephyr Cove, NV 89448  
(775)588-9188

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***Commitment to Patient Safety***

Lake Tahoe Surgery Center is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

***Mission, Vision, and Values***

In support of the mission, vision, values, and strategic plan of Barton Health, Lake Tahoe Surgery Center's Patient Safety program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.
- An environment and culture where patients, families, staff and leaders within the organization identify and manage actual and potential risks to patient safety thereby resulting in zero harm.
- An ongoing proactive reduction in health-related errors including near miss and good catch events.
- Integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions, and services.

***Scope and Purpose***

The scope of this Patient Safety Plan is specific to Lake Tahoe Surgery Center, a department of Barton Health, which includes but is not limited to:

- Patient safety
- Visitor safety
- Employee safety

All Lake Tahoe Surgery Center staff are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process. Each employee performs a critical role in patient safety and thus, Barton Health's journey to becoming a high reliability organization. All Barton Health-Lake Tahoe Surgery Center team members are focused on providing consistently exceptional care through an environment that supports teamwork, collaboration and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to patient safety while setting expectations for those who work in the organization. Leadership evaluates the culture of safety on a regular basis.



This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Lake Tahoe Surgery Center has developed this Patient Safety plan.

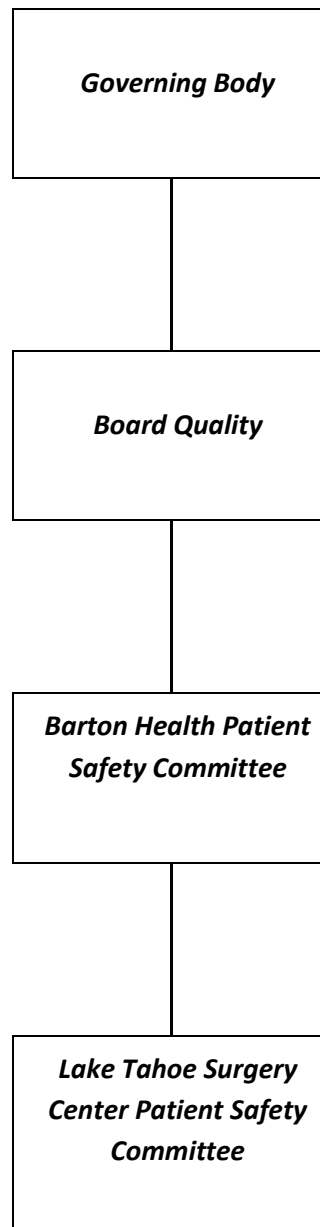
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff.

***Roles and Responsibilities***

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee reporting hierarchy:

***Roles and Responsibilities***

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The Patient Safety Officer of the medical facility. At Barton Health, the Director of Patient Safety has oversight of the Patient Safety Officer and serves in this role;
- The infection preventionist of the medical facility;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and

- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

Lake Tahoe Surgery Center Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the Patient Identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Director of Patient Safety/Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Department in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least quarterly, due to the number of employees in the facility, report to the executive or governing body of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Lake Tahoe Surgery Center Patient Safety Committee will meet quarterly to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate patient safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.
- A meeting agenda and minutes noting follow-up tasks will be kept.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

RCA Team Leader/Facilitator Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create a RCA process that incorporates Patient Safety Improvement elements.

Director of Patient Safety (based on NRS 439.870)

- Provide oversight to the integrated Barton Health patient safety program.
- Serve on the Lake Tahoe Surgery Center Patient Safety Committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the Lake Tahoe Surgery Center Patient Safety Committee, Patient Safety Committee, Board Quality and Governing Board actions taken related to the sentinel event.
- Ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.
- Oversee, monitor and evaluate safety activities, manage the program that measures and analyzes safety levels, and help identify problem areas for correction.
- The Director of Patient Safety has the authority to intervene in any clinical or non-clinical activity which poses an actual or potential negative outcome to a patient's well-being. The Director of Patient Safety involves leadership in the creation, initiation and evaluation of corrective action measures for event resolution.
- Report to the Patient Safety Committee regarding any action taken in accordance with the responsibilities above.

Infection Preventionist Responsibilities (based on [NRS 439.873](#))

- Serve on the Lake Tahoe Surgery Center Patient Safety Committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the Patient Safety Committee concerning the number of infections at the facility.
- Take such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Executive Member Responsibilities

- Provide vision and leadership to the Lake Tahoe Surgery Center Patient Safety Committee and develop and foster a safe learning and improving culture.
- Provides oversight to the integrated patient safety program
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient

safety action plans.

- Ensure alignment of patient safety activities, compliance with regulations, and provide opportunities for all Barton Health team members to be educated and involved in patient safety initiatives.

***Objectives and Goals of the Patient Safety Plan***

Objective	Goals	Plan	Planned Completion Date	Responsible Party
To control known and potential safety hazards to patients, visitors, and staff.	Strive for zero harm.	Patient Safety Plan as presented	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To establish a safety program that incorporates all activities within Lake Tahoe Surgery Center which contribute to the maintenance and improvement of staff and patient safety and reduction of medical/health care errors.	Provide education to all staff on the elements of the Lake Tahoe Surgery Center Patient Safety Plan.	Education provided upon hire	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

To create a culture in which patients, visitors and employees can identify and manage actual and potential risks to patient and staff safety.	In-service all personnel on the use and completion of event reports.	Education provided upon hire	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To develop a culture that encourages recognition and acknowledgement of risks to safety including medical health care errors, facility-acquired infections, initiation of actions to reduce risks, internal minimization of individual blame or retribution, and organizational learning about errors.	Reduce the risk of safety related incidents by proactively evaluating systems in place and making any necessary changes.	Evaluate near-miss events through RCAs and PIs presented at Patient Safety Committee and encourage Just Culture changes	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
To develop an environment that supports sharing of knowledge to affect behavioral changes in itself and other healthcare organizations to improve patient safety.	Reduce the risk of safety related incidents by proactively evaluating systems in place and making any necessary changes.	Evaluate near miss events through RCAs and PIs presented at Patient Safety Committee and encourage Just Culture changes	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.

Empower patients to understand and participate in their healthcare.	Provide communication and education to patients relating to their care.	Provide education through various methods based on learning assessment.	Ongoing	The Director of Patient Safety and Patient Safety Committee presiding over Barton Health are responsible for managing and coordinating the organization-wide safety program in collaboration with other departments, services and disciplines including Lake Tahoe Surgery Center.
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### ***Components and Methods***

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.

### **Patient Safety Risk Reduction**

Several approaches are utilized at Barton Health to reduce the risk of a patient safety event. The Joint Commission's National Patient Safety Goals, National Healthcare Safety Network (NHSN) Institute for Healthcare Improvement (IHI), Agency for Healthcare Research and Quality (AHRQ), Hospital Quality Institute, and California Hospital Patient Safety Organization (CHPSO) are some examples of utilized resources to prevent and reduce the likelihood of serious patient safety events. Sentinel Event Alerts released through The Joint Commission are also analyzed for compliance.

### ***Sentinel Event Alerts***

Sentinel Event Alerts, published through The Joint Commission, are communicated through the Patient Safety Committee. Compliance status and opportunities for improvement are addressed through workgroups consisting of affected Department Directors, Executive Team Members and others as appropriate to formulate risk reduction strategies and follow up through an action plan. Action items within the action plan are assigned to individuals who are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

### ***Scientific Model Integration***

The patient safety program has been developed with scientific knowledge in a foundational aspect including concepts from:

- Shewhart cycle or Model for Improvement (Plan, Do, Study, Act –PDSA)
- Failure Mode and Effects Analysis (FMEA)
- Re-engineering (Human factor re-engineering such as signage for High Alert Medications, pop up alert in Pyxis medication dispensing system, tall man lettering for look-alike sound alike drugs in medication usage process, etc.)
- Rapid Cycle Improvement (Institute of Health Care Improvement (IHI)) Collaborative approach termed the 'Breakthrough Series', to bring about rapid cycle improvements. Fundamental to the collaborative approach is

the acceptance of a model and establishment of infrastructure through which collaborating organizations can identify and prioritize aims for improvement and gain access to the methods, tools, materials etc.)

- RCA<sup>2</sup>: Improving Root Cause Analyses and Actions to Prevent Harm
- Process Improvement (PI) such as Lean and Six Sigma concepts
- Evidence-based practice and clinical practice guidelines

### **Educational Enhancement Activities**

The Patient Safety Plan provides the opportunity to reduce patient safety events and hazardous conditions through education, proper and effective orientation, and annual training. Barton Health's clinical orientation program emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing patient safety training for Barton Health team members including practitioners is offered through various teaching strategies including, but not limited to, bulletin boards, online learning formats, skills labs, and didactic experiences. Program content may include education specific to patient safety related events or advancements in patient safety practice. As appropriate, this training incorporates methods of team training such as TeamSTEPPS by AHRQ to foster an interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and mechanisms to report patient safety concerns.

### **Investigation: Root Cause Analysis and Process Improvements**

In any event when an adverse/sentinel event or hazardous condition has occurred, the issue is revisited and the status mitigated through a risk reduction strategy using the Root Cause Analysis (RCA) process. Lesser events are managed through either an RCA or Process Improvement (PI). Reportable Adverse or Sentinel Events shall be subject to an immediate in-depth RCA.

RCAs shall be convened by the Director of Patient Safety or designee and includes team members either directly or indirectly involved in the event. Members from uninvolved departments may be invited to provide additional information. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting the RCA. The Root Cause Analysis and Action Plan Framework Table, introduced by the Joint Commission, contains 24 analysis questions that guide the organization through the steps in a root cause analysis. Not all the questions apply to all the events or cases. The 5 Whys technique will be used to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. During the RCA, events are deconstructed in an effort to identify the key causes that may have contributed to the event. The deconstruction process leads to action items designed to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors. The Veterans Affairs National Center for Patient Safety Action Hierarchy is used to assure strong corrective action items are identified.

An RCA meeting will meet as needed to accomplish the following:

Define the healthcare issues or potential risks.

- Conduct Root Cause Analysis
  - Review and analyze the data.
  - Review the RCA process and improvement related activities and timelines.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Discuss corrective action process and activities.



- Discuss and present possible changes in procedure to improve areas indicated.
- Identify strengths and areas that need improvement.
- Develop strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

Process Improvement teams are formed when an issue affecting more than one service line is identified and a near miss may or may not be involved. There may be no adverse patient outcome in connection with the event, however, the potential for a patient event should the issue recur is likely. PIs may also result from discussions during RCAs where a system improvement process is identified as a result of a patient event. Team members convene and identify key factors involved in the process through deconstruction that may have contributed to the situation and create action items to mitigate the identified issues.

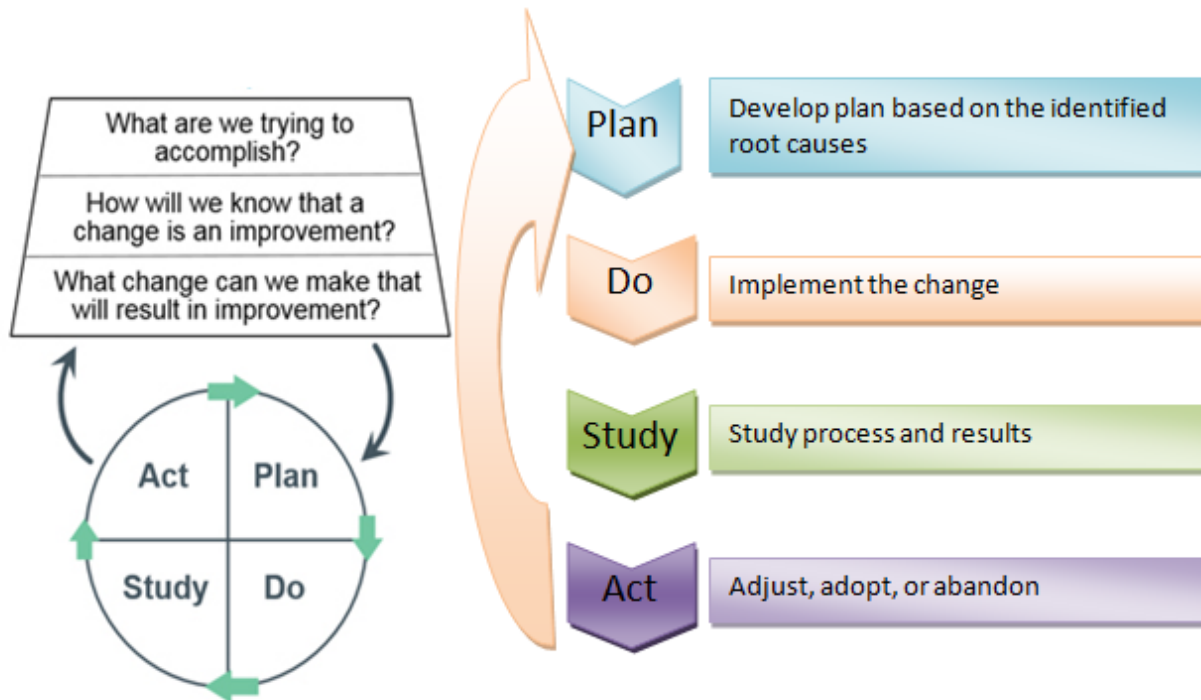
RCA and PI workgroups construct action items and assign them to appropriate individuals for completion. Staff involvement is considered essential, since they are the team members on the front line with the most knowledge of the actual day-to-day workings of the processes. Individuals assigned action items are required to complete the tasks within a designated amount of time depending upon the breadth of the item. Action items may be forwarded to other appropriate bodies for further in-depth evaluation, review, response, revision, or development of policies or procedures when applicable. Action item progress and completion is reported to the Patient Safety Department.

As a learning organization utilizing Just Culture, Barton Health focuses on systems and processes, not individuals, during RCA or PI event review.

Lake Tahoe Surgery Center will use the RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study-Act (PDSA) is the model, which was developed by the Institute of Health Care Improvement that will be utilized to test the changes.

## Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve product, services and processes. It provides multi-disciplinary team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- **Plan**--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
  - What is the objective of the test?
  - What are the steps for the test - who, what, when?
  - How will you measure the impact of the test?
  - What is your plan to collect the data needed?
  - What do you predict will happen?
- **Do**--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?
- **Study** -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?
- **Act**--If the result is successful or desirable, standardize the changes and then work on the next prioritized

problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

### **Data Collection and Reporting**

Data should drive patient safety efforts. Lake Tahoe Surgery Center utilizes an electronic event reporting system for tracking events, sentinel events, healthcare infection data, and information for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for the Patient Safety plan include data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

### **Ongoing Reporting and Review**

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report as needed 2) Severity of infection report as needed 3) RCA assessment as needed	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Patient Safety Plan update 2) Review and revise Patient Safety checklists and policies

### **Assessment of the Patient Safety Plan**

The Patient Safety Committee shall review and assess/approve this plan at least once a year, but more often as necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices.

### ***Patient Safety Checklists and Patient Safety Policies***

In accordance with [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure the patient's room and environment is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient. Refer to Barton Health's Patient Identification policy.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene. Refer to Barton Health's Hand Hygiene policy.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials. Refer to Patient Safety Observational Tracers policy.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in LTSC Attachment A.

The patient safety policies are listed in LTSC Attachment B.

***Approval of Patient Safety Plan***

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. At Barton Health, this is accomplished by the plan being approved through the Lake Tahoe Surgery Center Patient Safety Committee, the Barton Health Patient Safety Committee, Board Quality and the Governing Board. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

**Authority**

The authority to implement the Patient Safety Plan rests with Barton Health's Governing Body, Board Quality Committee, Medical Executive Committee, and Patient Safety Committee.

***2020 Lake Tahoe Surgery Center Patient Safety Priorities***

During 2020, Lake Tahoe Surgery Center will strive to achieve two different priorities to ensure safe patient care. During 2019, the surgical site infection rate was zero. Staff education was provided during the year. In 2020, LTSC would like to maintain a surgical site infection rate of less than 0.5%.

Lake Tahoe Surgery Center had zero never events during 2019. In an effort to reduce the potential for harm, Lake Tahoe Surgery Center will strive to maintain zero harm during 2020. Physician and staff education is ongoing. The Patient Safety Committee reviews all event reports and action items will be assigned to the appropriate staff. Education will occur immediately following an event, near miss or good catch.

## References

Agency for Healthcare Research and Quality. (2014). *The patient safety and quality improvement act of 2005*. Retrieved from <http://www.ahrq.gov/policymakers/psoact.html>

Centers for Disease Control and Prevention's National Healthcare Safety Network. (2016). *Healthcare-associated infections (HAIs)*. Retrieved from <http://www.cdc.gov/hai/>

Nevada Division of Public and Behavioral Health. (2019). *Sentinel event registry*. Retrieved from [http://dpbh.nv.gov/Programs/SER/Sentinel\\_Events\\_Registry\\_\(SER\)-Home/](http://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_(SER)-Home/)

Nevada Revised Statutes. Health and safety of patient at certain medical facilities. NRS 439.800-439.890

The Joint Commission Standard APR.09.02.01

The Joint Commission Standard LD.04.04.05

The Joint Commission. (2019). Ambulatory Health Care: 2020 *National Patient Safety Goals*. Retrieved from [https://www.jointcommission.org/assets/1/6/NPSG\\_Chapter\\_AHC\\_Jan2020.pdf](https://www.jointcommission.org/assets/1/6/NPSG_Chapter_AHC_Jan2020.pdf)  
[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 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)

**LTSC Attachment A: Terms and Definitions**

**Patient Safety:** The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

[http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick\\_110.pdf](http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf)

**Sentinel event (NRS 439.830):**

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

**Facility-Acquired Infection (NRS 439.802):**

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

**Medical facility (NRS 439.805):**

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).



(Added to NRS by [2002 Special Session, 13](#))

**Near miss:** An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Mandatory reporting:** Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

**Risk:** Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

**Preventable event:** Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Catheter Associated Urinary Tract Infection (CAUTI):** A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place for greater than 2 calendar days on the date of event, with day of device placement being Day 1, and an indwelling urinary catheter was in place on the date of event or the day before. If an indwelling catheter was in place for greater than 2 calendar days and then removed, the date of event for the UTI must be that day of discontinuation or the next day for the UTI to be catheter-associated (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN): Patient Safety Component Manual; 2017. Available at [https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual\\_current.pdf](https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf)

**Central Line Associated Bloodstream Infections (CLABSI):** Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

**LTSC Attachment B: Patient Safety Patient Safety Checklists & Policies for Lake Tahoe Surgery Center****REPORT TO THE DIRECTOR OF THE LEGISLATIVE COUNSEL BUREAU PURSUANT TO ASSEMBLY BILL 280 OF THE 2011  
LEGISLATIVE SESSION – SUBMITTED BY:**

Lake Tahoe Surgery Center

212 Elks Point Rd Suite 201, Zephyr Cove NV 89448

Lindsey Wharton RN, Director and Administrator of Perioperative Services

YEAR – June 1, 2018 – June 30, 2019

Check Lists Include:	Developed	Revisions*	Usage**	Review***
Related to the following specific types of treatments*		(date of revision)	(Unit/department)	
Patient Room & Environment Sanitation (Cleaning Checklists)		June 29, 2015	ASC	X
Discharge Checklist		October 28, 2014	PACU	X (on EMR)
Pre-op Checklist		May 2, 2015	PRE-OP/OR	X (on EMR)
Safety Checklist	May 2, 2015	June 1, 2016	OR	X (on EMR)
Sign-In	May 2, 2015	June 1, 2016	OR	X (on EMR)
Fire Safety	May 2, 2015	June 1, 2016	OR	X (on EMR)
Timeout	May 2, 2015	June 1, 2016	OR	X (on EMR)
Sign-out	May 2, 2015	June 1, 2016	OR	X (on EMR)
Environmental Rounds (quarterly)		November 3, 2015	ASC	X
Infection Control Survey (monthly)			ASC	X
Surgical Services Audit		June 29, 2015	ASC	X
Incubation Temperature			STERILIZATION	X
Medication Refrigerator		May 2013	PRE-OP/PACU/OR	X
IVF/Blanket Warmer Temperature		April 25, 2016	PRE-OP/PACU/OR	X
Sage Warmer		February 3, 2016	PRE-OP	X
OR Temperature/Humidity		December 18,	ASC	X

		2014		
Washer Sterilizer Cleaning			STERILIZATION	X
Daily, weekly, monthly duties		April 21, 2016	PRE-OP/PACU/OR	X
Crash Cart		May 2018	NURSING	
Pediatric Crash Cart		May 2018	NURSING	
Malignant Hyperthermia Cart		January 25, 2016	NURSING	X
Hand Hygiene Audit			ASC	X
Medication Labeling Audit		December 8, 2016	ASC	
<b>Patient Safety Policies Include:</b>	<b>Developed</b>	<b>Revisions</b>	<b>Usage</b>	<b>Review</b>
Patient Identification			ASC	X
Hand Hygiene		December 20, 2017	ASC	X
Patient Safety Checklist			ASC	X
National Patient Safety Goals		2018	ASC	
Medication Reconciliation			ASC	X
Handoff Communication			ASC	X
Universal Protocol			ASC	X
Safe Preparation and Administration of Medications		April 2018	ASC	
General Safety Policy- Patients/employees			ASC	X
Hazard Communications			ASC	X
Injury and Illness Prevention Program Plan			ASC	X
OSHA Reporting/Injury Reporting			ASC	X
Material Safety Data Sheets			ASC	X
Exposure Control Plan			ASC	X


Abusive Behavior- Patients			ASC	X
Abusive Behavior- Non-patients			ASC	X
Disruptive Physician or Ancillary staff Behavior			ASC	X
Identification of Life Safety Code Deficiency			ASC	X
Fire Risk Assessment			ASC	X
<b>Summary of Review</b>	<b>Total # developed</b>	<b>Total # revised</b>	<b>Total # Reviewed</b>	
Patient Safety Checklists	0	2	21	
Patient Safety Policies	0	3	16	

\*Checklists and Patient Safety Policies were reviewed for the stated time period. Need for revision is noted by the date the revision was made.

\*\*Usage outlines the unit/departments the checklists are used in.

\*\*\*As part of the annual review any required revisions will be identified. If revisions are required this is noted in the revision box. Any additional patient safety checklists or policies identified will be noted in this (review) column. If the annual review reveals no changes are required this box will be marked with an "X". An "X" means that the checklists and policies were reviewed but no changes were required.

Reports are due on or before July 1 of each year

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## PURPOSE:

- I. The purpose of the Patient/Resident Safety Plan (PRSP) is to improve patient safety and reduce risk to patient/residents through an environment that promotes:
  - a. Recognition and acknowledgment of risks to patient safety and medical/health errors;
  - b. The initiation of actions to reduce these risks;
  - c. The internal reporting of findings and the actions taken;
  - d. A focus on processes and systems;
  - e. Minimization of individual blame or retribution for involvement in a medical / health care error;
  - f. Organizational learning about medical/health care errors and safety factors;
  - g. Support of the sharing of knowledge to effect behavioral changes within Boulder City Hospital (BCH)
  - h. Individual responsibility to identify report and participate in the solution of safety risks.


## POLICY:

**NOTE: The term Patient will be used throughout this policy to represent patients, residents and clients.**

- I. The PRSP provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through:
  - a. The establishment of mechanisms that support effective responses to actual occurrences;
  - b. Ongoing proactive reduction in medical / health care errors; and
  - c. Integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
  - d. Zero tolerance for workplace violence. BCH strives to maintain a harmonious work environment free from violence and intimidation. Weapons of any kind are prohibited. Violent acts, threatening, harassing, discriminating, disruptive behavior (conflict that disrupts the work and jeopardizes the safety of individuals) and/or coercing behavior are prohibited and may result in disciplinary action up to and including termination (for employees) and/or legal action as warranted.
- II. As patient care and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the activities to maintain patient safety. This plan works in conjunction with the facility-wide Safety/Emergency Preparedness Manual which has inter-facility and department specific policies as necessary to address safety concerns such as Fire, Emergency Preparedness for Internal and External Disasters, Pandemic Events, etc.  
The PRSP was developed by the interdisciplinary Safety Committee and approved by the Medical Staff, Board of Trustees and Administration and outlines the components of the organization's PRSP.

## PROCEDURE:

- I. Scope of Activities
  - a. Ongoing assessment, monitoring, tracking and trending with analysis using internal and external knowledge and experience to:
    - i. Prevent error occurrence
    - ii. Maintain and improve patient safety
  - b. Patient/Resident Safety Occurrence Information:
    - i. Collected from aggregated data reports and individual occurrence reports.
    - ii. Will be reviewed by the Safety Committee.
    - iii. Is used to prioritize organizational patient safety activity efforts.
- II. Types of Patient/resident Safety or Medical/Health Care Errors
  - a. No Harm Errors
    - i. Unintended acts, either of omission or commission;


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- ii. Acts that do not achieve their intended outcome; and/or
  - iii. Acts that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, to the patient
- b. Mild to Moderate Adverse Outcome Errors
  - i. Any medication error (mindful of the errors that result from: incomplete and/or inaccurate medication orders, transcription and documentation; not adhering to the 5 rights of medication administration; inappropriate labeling as well as in appropriate monitoring and storage of medications)
  - ii. Any Adverse Drug Reaction (ADR)
  - iii. Any transfusion reaction
  - iv. Hazardous Condition
    - 1. Any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
  - v. Any Healthcare Associated Infection (HAI) including but not limited to Central Line Associated Blood Infections (CLABSI); Catheter Related Urinary Tract Infections (CAUTI); c-diff infections
  - vi. Any Health Care Associated Stage III or IV Pressure Ulcer
  - vii. Any patient falls with injury
  - viii. Any patient aspiration
  - ix. Any motor vehicle accident wherein a patient was a passenger
- c. Sentinel Event (SE):
  - i. Unexpected adverse occurrence involving death or serious injury or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. A sentinel event is an adverse event of a severe and urgent nature that can result in an unexpected and undesirable patient outcome. (Example: Surgery on the wrong patient or removal of the incorrect limb). The phrase "the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. A Sentinel Event: (Refer to BCH Policy, "Sentinel Events")
  - ii. Potentially involves a continuing threat to patient care or safety
  - iii. Has significant potential for being reflective of serious underlying systems problems within an organization
  - iv. Potentially undermines public confidence in the organization
  - v. A "Near Miss" is any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Refer to BCH Policy, "Sentinel Events" For this policy, all reference to Sentinel Events includes Near Miss events as well.

### III. Scope of Program

- a. Encompasses:
  - i. Patient, resident and client population;
  - ii. Visitors;
  - iii. Volunteers; and
  - iv. Staff (including Medical Staff)
- b. Addresses:
  - i. Maintenance and improvement in patient/resident safety issues in every department throughout the facility
  - ii. Emphasizes hospital and patient care functions of:
 

Ethics, Rights & Responsibility	Management of the Environment of Care
Provision of Care	Management of Human Resources
Medication Management	Management of Information
Improving Organization	Surveillance, Prevention and Control of Infection
Performance	
Leadership	

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c. Assures:

- i. All departments have current Safety Manual available on-line
- ii. Emergency Preparedness Quick Reference Guide "Red Book" is available in high traffic areas
- iii. Senior Leaders are FEMA trained (100,200, and 700) and NIMS compliant
- iv. Hospital Decontamination Program (and related equipment) is available and compliant with current regulations
- v. Enforced Hand Hygiene policy
- vi. Adherence to Standard Precautions with implementation of Isolation Precautions when necessary
- vii. Maintenance of a sanitary environment through interdepartmental collaboration, product and service evaluation and monitoring effectiveness

IV. Methodology

a. Responsibility

- i. The Committee meets monthly and is responsible for oversight of the Patient/Resident Safety Program
- ii. The Patient Safety Officer will have Administrative responsibility for the program

b. Membership will include but not be limited to:

- |   |  |
|---|--|
| i. Safety Officer                                 | viii. Acute Nursing Services Representative  |
| ii. Physician                                     | ix. Purchasing/Central Supply Representative |
| iii. Chief Nursing Officer/Patient Safety Officer | x. Environmental Services Representative     |
| iv. Pharmacy Staff Representative                 | xi. Chief Executive Officer                  |
| v. Human Resources Representative                 | xii. Risk Manager                            |
| vi. Laboratory Representative                     | xiii. Infection Control Nurse                |
| vii. Long Term Care Representative                | xiv. Program Manager                         |


c. Communication

- i. **All departments**, both patient care and non-patient care are responsible to report patient safety occurrences and potential occurrences to the Risk Manager. Through the Quality Reporting and Resolution system (QRR)
- ii. Risk Manager will aggregate occurrence information and present a report to the Committee on a quarterly basis.
- iii. The report will contain aggregated information related to:
  1. Type of occurrence;
  2. Severity of occurrence;
  3. Number/type of occurrences per department;
  4. Occurrence impact on the patient;
  5. Remedial actions taken; and
  6. Patient/resident outcome.
- iv. The Committee will:
  1. Analyze the report information; and
  2. Determine further patient safety activities as appropriate.
- v. The Committee will make recommendations for action and implementation and will follow-up as appropriate. Safety information is relayed to Department Managers, the Medical Executive Committee and the Board of Trustees who will then share the information during meetings and/or through communiqués.

V. Review of Internal and External Reports


a. To include, but not be limited to:

- i. Sentinel event report information;
- ii. HAI statistical report;
- iii. Fire and Disaster Drill reports;
- iv. Occurrence reporting;


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- v. Injury Report;
  - vi. Information from state and federal sources;
  - vii. Current literature;
  - viii. Performance Improvement reports.
  - ix. Safety Survey results (performed at least annually)
- b. The Committee will select at least one high-risk safety process for an annual proactive risk assessment.
- c. The proactive risk assessment will include:
  - i. Assessment of the intended and actual implementation of the process.
  - ii. Identify the steps in the process if there may be any undesirable variations.
  - iii. Identification of possible effects of the undesirable variation on patient/residents.
  - iv. How serious the possible effects on the patient/resident could be.
  - v. For the most critical effects, conduct a failure mode event analysis (FMEA) to determine why the undesirable variation leading to that effect may occur.
  - vi. Redesign the process and/or underlying systems to:
    - 1. Minimize the risk of that undesirable variation; or
    - 2. Protect patient/residents from the effects of that undesirable variation.
  - vii. Test and implement the redesigned process.
  - viii. Identify and implement measures of the effectiveness of the redesigned process.
  - ix. Implement a strategy for maintaining the effectiveness of the redesigned process over time.
- VI. Identification of a Medical/Health Care Error
  - a. Note that the following Quality Improvement Policies are pertinent to this section: Medication Errors [HWN 139], Decreasing Medication Errors [HWN 142] and Safe Medication Practices [HWN 145]
  - b. The staff member will immediately:
    - i. Perform and/or obtain necessary healthcare interventions to protect and support the patient's clinical condition;
    - ii. As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of any recalled item from stock.
    - iii. Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary;
    - iv. Preserve any information related to the error including physical information such as:
      - 1. Removal and preservation of blood unit for a suspected transfusion reaction;
      - 2. Preservation of IV tubing, fluids bags and/or pumps for a patient/resident with a severe drug reaction from IV medication;
      - 3. Preservation of medication label for medications administered to the incorrect patient/resident;
      - 4. Documenting the facts regarding the error in the medical record as appropriate to organizational policy and procedure;
      - 5. Reporting the medical/health care error to Department Director and Attending Physician; and,
      - 6. Enter the occurrence report into the Quality Review Report system. Risk Manager will review.
  - c. Any individual in any department identifying a potential patient safety issue will:
    - i. Immediately notify his/her supervisor; and
    - ii. Document the findings in QRR system.
  - d. Patient, and family member as appropriate; and officiating agency will be notified timely of safety concerns and/or medical errors including HAI, ADR, SE, etc.
- VII. Response
  - a. Staff response to medical/health care errors is dependent upon the type of error identified.
  - b. Error types:
    - i. Near miss
      - 1. Report the near miss event to immediate supervisor;
      - 2. Describe the facts of the near miss in the QRR System



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- ii. No harm errors (including “no harm” medication errors)
  1. Document appropriately in the medical record according to policy;
  2. Document the circumstances regarding the no harm error in the QRR system; and
  3. Notify the immediate supervisor.
- iii. Mild to moderate adverse outcome errors (including medication errors)
  1. Perform any necessary clinical interventions to support and protect the patient/resident;
  2. Notify the physician and staff responsible for the patient/resident;
  3. Carry out any necessary physician orders;
  4. Preserve any physical evidence as appropriate;
  5. Notify immediate supervisor;
  6. Document facts appropriately in the medical record and in the QRR system.
- iv. Adverse Drug Reaction
  1. Perform any necessary clinical interventions to support and protect the patient;
  2. Notify the physician staff responsible for the patient;
  3. Execute any necessary physician orders;
  4. Preserve any physical evidence as appropriate;
  5. Notify immediate supervisor;
  6. Document facts appropriately in the medical record and in the QRR system;
  7. Report ADR to Pharmacy via an ADR form; and
  8. Notify patient/resident and/or family
- v. Transfusion Reaction
  1. Perform any necessary clinical interventions to support and protect the patient;
  2. Notify the physician responsible for the patient;
  3. Carry out any necessary physician orders.
  4. Follow the Administration of Blood and/or Blood Products and the Adverse Reaction to Blood Transfusion policies in House Wide P & P Manual including completion of a QRR
- vi. Hazardous Condition Patient Safety Issue
  1. As appropriate, and if possible, staff will:
    - a. Contain the hazardous condition or patient safety issue;
    - b. Immediately notify supervisor;
    - c. Document the findings in the QRR System;
    - d. Notify patient
    - e. Notify agencies as appropriate
  2. BCH has identified three significant clinical safety concerns based on the age of the population we serve and the historical data analyzed:
    - a. Falls with injuries
    - b. Aspiration
    - c. Hospital Acquired Infection
  3. For significant safety concerns, BCH has established:
    - a. A mechanism to identify individuals at risk
    - b. Plans to prevent the occurrence of these safety concerns
    - c. A reporting mechanism using the Quality Review and Report system (internal) to track, trend and analyze data reporting to the appropriate internal committees including the Safety Committee, Quality Improvement Committee, Medical Quality Improvement Committee, Medical Executive Committee, and the Board of Trustees
    - d. Timely forward reporting of pertinent information to applicable agencies including but not limited to the State of Nevada Bureau of Health Care Quality and Compliance, the Ombudsman, the Sentinel Event Registry, the Southern Nevada Health District, etc.
    - e. At a minimum annual staff education regarding these safety concerns


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vii. Sentinel Event

1. Perform any necessary clinical interventions to support and protect the patient;
2. Notify the physician and staff responsible for the patient;
3. Carry out any necessary physician orders; and
4. Notify the patient documenting notification;
5. Follow the Sentinel Event Policy and Procedure (see BCH Policy "Sentinel Events" in House Wide P & P Manual).
6. Report event to the appropriate committees including Safety, Quality Improvement and Medical Quality Improvement, Medical Executive and Board of Trustees

VIII. Organizational Response

- a. Established policy and/or the Hospital Quality Improvement Committee will determine the organizational response to medical/health care errors and occurrences.
- b. Sentinel events and "Near Misses" will have a root-cause analysis conducted.
- c. The Committee, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
  - i. Further remedial action activities necessary for identified occurrences;
  - ii. Proactive occurrence reduction activities; and
  - iii. Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities.
- d. Resolution
  - i. Non-Punitive Approach
    1. An effective Patient/Resident Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences.
    2. The intent of this institution is to adopt a non-punitive approach in its management of errors and occurrences.
    3. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment.
    4. This organization supports the concept that errors occur due to a breakdown in systems and processes.
    5. Focus will be given on improving systems and processes rather than disciplining those responsible for errors and occurrences.
    6. A focus will be placed on remedial actions to assist rather than punish staff members.
    7. The Committee and the individual department Managers will determine the appropriate course of action to prevent error recurrence.
  - ii. Sentinel Events
    1. Staff members involved in a sentinel event occurrence will receive support to facilitate the staff member's professional and emotional reconciliation of the sentinel event.
    2. The staff member will be allowed an active role in process resolution as well as the root-cause analysis and action plan processes.
    3. Any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling as per the Sentinel Event Policy and Procedure and Employee Assistance Program.
- e. Evaluation
  - i. The Patient/Resident Safety Program includes an annual survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient/resident safety.
  - ii. In keeping with a non-punitive philosophy designed to encourage reporting and resolution of errors, the staff will be queried annually regarding safety concerns including their willingness to report medical/health care errors.
- f. Education
  - i. Staff will receive education and training:
    1. During their initial orientation process; and

 Boulder City Hospital Quality care close to home		Patient/Resident Safety Plan	
		DEPARTMENT: Emergency Preparedness Plan	
APPROVED BY: Safety Committee		REFERENCE # SEP 015	Page 7 of 7
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2. On an ongoing basis regarding job-related aspects of patient safety.
- ii. Education and training will include:
  1. The need and method to report medical/health care errors and other safety concerns;
  2. Providing the optimal provision of healthcare in an interdisciplinary manner; and
  3. An interdisciplinary approach to patient care.
- g. Reporting
  - i. BCH values transparency working together as an organization accountable to the licensing and quality agencies as well as to our patients, staff, medical staff, volunteers and our community
  - ii. Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally per hospital policy and through the channels established by this plan.
  - iii. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Refer to House wide policy HWN 135 Reportable Events.
  - iv. Patient safety reports from the Safety Committee will be submitted to the Medical Executive Committee and the Quality Improvement Committee.
  - v. The Board of Trustees has the opportunity to review and ask questions during the monthly meeting as the minutes of committees are contained within the Medical Executive Committee minutes for approval by the board.

## **Mission Statement Policy**

### **Policy No. 4-001**

#### **Policy**

BrightStar Care will have a mission statement.

#### **Mission**

BrightStar Care of W. Central Las Vegas is guided by a tradition of personal, clinical, and technological excellence.

We are dedicated to providing the highest quality home-based patient care with compassion and respect for each person.

#### **Values**

BrightStar Care of W. Central Las Vegas recognizes these values and their role in fulfilling our mission:

#### **Committed to Our Patients**

We recognize the unique physical, emotional, and spiritual needs of each person receiving health care in the home. We strive to extend the highest level of courtesy, safety and service to patients, family/caregivers, visitors, and each other.

#### **Committed to Leadership**

We deliver state-of-the-art home health services with identified centers of excellence. We engage in a wide range of continuing education, clinical education, and other programs for professionals and the public.

#### **Committed to Excellence**

We strive to create an environment of teamwork and participation, where, through continuous performance improvement and open communication, health care professionals pursue excellence and take pride in their work, the organization, and their personal development. We believe that the quality of our human resources—organization personnel, Licensed Prescribers, and volunteers—is the key to our continued success. We provide Licensed Prescribers an environment that fosters high quality diagnosis and treatment. We maintain financial viability through a cost-effective operation to meet our long-term commitment to the community.

#### **Committed to a Culture of Safety and Quality**

We strive to create a culture of safety and quality by developing a code of conduct, providing education, encouraging open communication, encouraging leaders to provide a team approach to safety and quality initiatives, providing leadership that defines how patients, family/caregivers, visitors, and other members of the community can help identify and manage issues of safety and quality, and implementing changes identified by the annual organization evaluation in order to maintain the culture of safety and quality.

**Governing Body  
No. 4-002**

**Policy**

The Governing Body of BrightStar Care of W. Central Las Vegas will serve as the governing authority for the home services program, which will function according to BrightStar Care of W. Central Las Vegas's bylaws/processes and will assume full legal authority and responsibility for the operation of BrightStar Care of W. Central Las Vegas.

**Procedure**

1. The Governing Body will review BrightStar Care of W. Central Las Vegas's bylaws/processes and other information relevant to the quality of patient care (i.e., unusual occurrences in care delivered is also consistently provided through a defined process) at least annually.
2. Meeting minutes will be maintained for each meeting.
3. The Governing Body will implement a written conflict of interest policy that includes guidelines for the disclosure of any existing or potential conflict of interest.
4. The Governing Body will consist of the agency owner/designee and at least one other individual.

## **Professional Advisory Committee Policy No. 4-003**

### **Policy**

The Governing Body will appoint a multidisciplinary Professional Advisory Committee (PAC). The committee will consist of at least one (1) practicing Licensed Prescriber, a nurse with community health or home care experience, and advocates of other professional services reflecting the scope of organization services (such as physical, speech, or occupational therapy, social work, and discharge planning). At least one member of the committee is neither an owner nor an employee of the organization. Organization members should be individuals who are aware of the needs of the community related to the population served. This requirement will be based on individual state requirements for such a committee.

This committee will meet at least annually, or more often as needed, and minutes of each meeting will be recorded. The committee's purpose is to assist the Executive Director/Administrator in an annual and ongoing review of the organization's operation. The annual evaluation will be submitted to the Governing Body for review and approval.

### **Procedure**

1. The committee will establish and review policies and procedures and oversee regulatory compliance in the following areas:
  - A. Admission and discharge policies and procedures
  - B. Policies governing scope of services offered
  - C. Medical supervision
  - D. Development of plans of care
  - E. Emergency procedures
  - F. Clinical procedures
  - G. Patient clinical records
  - H. Personnel qualifications
  - I. Recruiting and retaining staff
  - J. Operating budget
  - K. Performance improvement plan
  - L. Compliance with law and regulation
2. The committee will evaluate the organization's success in meeting community needs for home care services, provision of adequate, safe, and appropriate care to each patient, and progress toward financial stability.

## **Responsibilities/Supervision of Clinical Services Policy No. 4-004**

### **Policy**

Supervision of clinical care and services will be available 24 hours a day, seven (7) days a week.

Supervisor-to-patient-care personnel ratios will depend on the acuity level of the patients and case-mix and will be in compliance with applicable law or regulation.

The Director of Nursing (DON) or registered nurse designee will be responsible for the clinical direction of the organization and will take reasonable steps to ensure that:

1. Services are continuously available
2. Care and services provided by organization personnel and contracted organization personnel are coordinated and integrated
3. Policies and procedures, which guide and support the provision of care and services, are developed and implemented
4. Recommendations for required resources are made in a timely and effective manner
5. Quality Assurance procedures are being performed by a registered nurse

The Director of Nursing (DON) will be qualified and possess appropriate clinical training and experience, as verified by:

1. Education, training, and previous work experience
2. Current professional licensure
3. Interview assessing understanding of care and service being provided as well as population being served
4. Management experience and clinical knowledge

### **Procedure**

1. The Director of Nursing (DON) or registered nurse designee will oversee the day-to-day clinical operations.
2. On a daily basis, staffing will be reviewed in combination with the patient census, acuity, etc.

- A. If staffing is problematic, the Director of Nursing (DON), and designees, will review options, such as:
    - 1. Use of outside contracted personnel
    - 2. Use of overtime by organization personnel
    - 3. Use of office nursing personnel (i.e., Clinical Supervisor, intake, QA/I nurses, etc.)
  - B. Any issue not resolved will be brought to the attention of the Executive Director/Administrator.
3. The Director of Nursing (DON) or designee will monitor the care and service provided by organization personnel and contract personnel. Monitoring includes the review of performance improvement results, incident reports, infection reports, clinical record review results, etc. Any noted trends of individual performance will be used during the evaluation process.
4. The Director of Nursing (DON) or designee will participate as a member on the following administrative teams:
- A. Professional Advisory Committee, if applicable
  - B. Clinical Operations Committee, if applicable
  - C. Performance Improvement Committee, if applicable
5. Recommendations regarding resources (personnel and other) and services will be made to the Executive Director/Administrator, as well as to the appropriate committee.
6. The Director of Nursing (DON) or designee will have access to qualified clinical consultation for services outside his/her expertise, through the use of the Licensed Prescriber and other resources, as appropriate.
7. The Director of Nursing (DON) or designee will ensure that the following supervision is maintained within the organization:
- A. Home care aides:
    - 1. Home care aide supervisory visits will be conducted on-site at a frequency dictated by the State Practice Act. Supervisory visits can be made in conjunction with the home care aide or in his/her absence.
  - B. Licensed practical/vocational nurse:
    - 1. LPN/LVN will be supervised by a registered nurse at a frequency dictated by the State Practice Act.
  - C. Supervisory visits will be made more often if indicated by the patient's and/or organization personnel's need.



## **Performance Improvement Policy**

### **Policy No. 4-005**

#### **Policy**

Senior management will carry the responsibility: to guide the organization's efforts in improving organizational performance in governance, management, clinical and support activities; to define expectations of the performance improvement activities; and to generate the plan and processes the organization will utilize to assess, improve and maintain quality of care and service.

All personnel will be active participants in the organization's performance improvement activities.

#### **Procedure**

1. Senior management will:
  - A. Participate in educational activities to increase their level of understanding and ability to implement performance improvement activities. The educational activities may include seminars, consultations, readings, periodicals, benchmarking, and review of available information from other organizations regarding the occurrence of sentinel events to reduce the risk of similar sentinel events within the organization.
  - B. Set expectations for performance improvement and manage processes to improve organization performance.
  - C. Focus on high risk, high volume, and problem-prone areas. Consider incidence, prevalence, and severity of problems in those areas and lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.
  - D. Adopt a scientific, problem-solving approach to performance improvement. The scientific, problem-solving approach will include, minimally:
    1. Planning for performance improvement with integration of information from other relevant activities
      - a. Risk management
      - b. Utilization management
      - c. Quality assurance
      - d. Infection control surveillance
      - e. Patient safety program
    2. Setting priorities for improvement and adjusting priorities in response to unusual or urgent events
    3. Systematic assessment of performance through comparison of organizational performance:

- a. Internally over time
  - b. To the performance of similar process in other organizations
  - c. To external sources of information
4. Implementing improvement on the basis of assessment and comparison data
5. Maintaining achieved improvements
6. Identifying and establishing activities to measure patient outcomes
- E. Ensure that new or modified services or processes are designed well and incorporate:
  1. Needs and expectations of patients, staff, and others
  2. Information about potential risks to patients, when available
  3. Current knowledge, when available and relevant
  4. Testing and analysis to determine whether design or redesign is an improvement
- F. Ensure that the organization adheres to the Joint Commission's published guidelines for describing information in its Quality Report.
- G. Ensure that the organization adheres to the Performance Improvement (PI) standards.
- H. Ensure that performance improvement projects are conducted that reflect the following standards:
  1. The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the organization's services and operations.
  2. The organization must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects.
- I. Allocate resources for assessing and improving the organization's performance by:
  1. Assigning organization personnel to participate in performance improvement activities
  2. Providing adequate time for organization personnel to participate in performance improvement activities
  3. Creating and maintaining information systems and data management processes to support collecting, managing and analyzing data to improve performance
  4. Utilizing appropriate statistical techniques to analyze and display data
    - a. Statistical facts may include:

1. Run charts that display summary comparison data
  2. Scatter diagrams
  3. Control charts that display variations and trends over time
  4. Histograms
  5. Pareto charts
  6. Cause-and-effect or fishbone diagrams
  7. Process flowcharts
5. Provide organization personnel training in effective approaches and methods of assessment and improvement
  6. Assessing the adequacy of human, information, physical, and financial resources allocated to support performance improvement and patient safety
- J. Analyze and assess the effectiveness of their contributions to improving organization performance, including review of leadership performance against pre-established, objective process criteria. The senior management, also, measure and assess the performance improvement and safety improvement activities.
2. Senior management will ensure that an integrated patient safety program is implemented throughout the organization by:
    - A. Assigning qualified individual(s) or an interdisciplinary group to manage the program
    - B. Defining the scope of the program's oversight
    - C. Establishing procedures for immediate response to system or process failures, and the internal and external reporting of such failures
    - D. Defining responses to various types of unanticipated adverse events and a process for conducting proactive risk assessment/risk reduction activities
    - E. Report, at least annually, to the Governing Body on system or process failures and actions taken to improve safety (both proactively and in response to actual occurrence)
  3. Senior management will ensure that the infection control program is an integral part of the organization's safety and performance improvement program by:
    - A. Participating in the design and implementation of the infection control program including the annual influenza vaccination program
      1. Sets incremental influenza vaccination goals
      2. Tracks vaccination rates of staff.
      3. Annually evaluates reasons given for declining the influenza vaccine
      4. Provides influenza vaccination data annually
    - B. Participating in educational activities to increase their knowledge
    - C. Establishing a process for ongoing assessment of the risks for acquisition and transmission of infectious agents

1. Sets goals for improving compliance with hand hygiene guidelines
- D. Establishing a process for at least annual review of the infection control program
4. All other organization personnel will:
  - A. Be involved in performance improvement activities
  - B. Promote communication and coordination of performance improvement activities, as well as contribute to those activities
  - C. Forward relevant information regarding performance improvement activities to senior management and to the Performance Improvement Coordinator or Director of Nursing (DON) or designee.
  - D. Take action on recommendations generated through performance improvement activities, as outlined in the organization's written performance improvement plan and as recommended in the Joint Commission's Sentinel Event Alerts and National Patient Safety Goals, based on care and service provided by the organization

## **Customer Service Satisfaction Survey Policy** **Policy No. 4-006**

### **Policy**

BrightStar Care vision is to be the world's premier provider of care and therefore quality service is one of the keys, paramount to this goal. BrightStar Care in conjunction with PatientImpact, Home Care Pulse and other companies who have been working to assist BrightStar Care with creating and implementing a patient satisfaction measurement tool, has developed a franchise wide system to report customer satisfaction. A survey will be administered via the mail or phone call with questions specific to BrightStar Care's services and clientele. Results are compiled in real time and delivered through online reports and comparative benchmarks. This will assist with a better understanding of our patients' needs and expectations assist in monitoring the quality of service our staff is providing and further differentiate and market BrightStar Care outstanding services.

### **Procedure**

1. A survey will be administered via the mail or phone call with questions specific to BrightStar Care's services and clientele.
2. The patient data is compiled and used to assist with patient management and quality improvements. Better understanding how a patient selected a service, assessing their comfort with staff, or determining their satisfaction with the billing process all foster better communication and a streamlined workflow to optimize the patient experience. This will assist with a better understanding of our patients' needs and expectations assist in monitoring the quality of service our staff is providing and further differentiate and market BrightStar Care outstanding services.

## Incident Report Policy Policy No. 4-007

### Policy

It is the policy of BrightStar Care that all incidents be reported. An incident is an unexpected or unusual occurrence involving a client, family member, visitor, guest or employee in relation to BrightStar Care services or employment. Types of incidents may include but are not limited to the following: medication error, fall, hospitalization, property damage, traffic violation, inappropriate behavior, injury, theft, vandalism, incidents that require a police report, employee injury which may additionally require completion of a Worker's Comp report, as well as any other occurrences presenting risks to patients or organization personnel..

The incident reporting system will be part of the organization's overall performance improvement and risk management plan. Staff are encouraged to report incidents or suspected incidents, without fear of blame or reprisal.

### Definitions

If the incident is a reportable event or sentinel event, refer to the appropriate applicable policy. For clarification the definition of an incident, a reportable event and a sentinel event is provided below:

**Incident:** An incident is an unexpected or unusual occurrence involving a client, family member, visitor, guest or employee in relation to BrightStar Care services or employment.

**Reportable event:** An event that could result in liability against a BrightStar Care Franchisee, damage to the BrightStar Care brand, or actions against a Franchisee's license.

**Sentinel event:** An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

**BrightStar Care Franchising and state specific reporting guidelines as well as those of accrediting bodies, if applicable, must also be followed.**

### Procedure

1. When an incident occurs, the following will occur:
  - a. The BrightStar Care office will be notified as soon as practical and an incident report should be completed out as soon (preferably within 24 hours) and as thoroughly as possible, including any action taken as a result of the incident.
  - b. The appropriate leadership staff/designee will review the incident report, request any necessary follow-up from appropriate personnel, and document accordingly.
  - c. The agency will follow up with the patient and family/caregiver, and/or patient's physician, if indicated.
  - d. The agency will maintain the confidentiality of the information. The report is for internal use only and is not available to other agents outside the organization.

- e. The agency will review a summary of incidents at a minimum, once per quarter during the Agency's Quarterly Quality Meeting and if applicable information should be forwarded to the Governing Body.
2. The agency ownership/designee should notify pertinent authorities as indicated. This includes BrightStar Care Franchise Support Center (e.g. Regional Field Support per the BrightStar Care Reportable Events policy), and may include your state licensing agency and the Joint Commission
3. Incidents requiring reporting to state and/or federal regulatory agencies:
  - a. All regulations and reporting forms will be available in the quality improvement department.
  - b. The agency ownership/designee will review incidents to determine if the event meets reporting criteria.
  - c. As applicable, the agency ownership/designee will complete and submit the necessary forms within the required time frame to the appropriate organization.
  - d. The agency ownership/designee will prepare and submit any subsequent or summary reports that may be required.
  - e. Reportable event files will be maintained according to applicable regulations.

## Sentinel Event Policy Policy No. 4-008

### Policy

A sentinel event and associated reporting requirements are part of the organization's overall performance improvement and risk management plan.

### Definition:

Sentinel event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

BrightStar Care Franchising and state specific reporting guidelines as well as those of accrediting bodies, if applicable, must also be followed.

Once a sentinel event occurs, it is important to conduct a root cause analysis to discover what went wrong and what systems, processes or practices could have been altered to reduce the likelihood of reoccurrence. See Root Cause Analysis Policy for details involved in a root cause analysis process.

### Procedure

1. When a sentinel event occurs, the individual discovering the event will:
  - a. The BrightStar Care office will be notified immediately, and an incident report should be completed immediately, including any action taken as a result of the sentinel event.
  - b. The appropriate leadership staff/designee will review the incident report, request any necessary follow-up from appropriate personnel, and document accordingly.
  - c. The agency will follow up with the patient and family/caregiver, and/or patient's physician, if indicated.
  - d. The agency will maintain the confidentiality of the information. The report is for internal use only and is not available to other agents outside the organization.
  - e. The agency will review a summary of incidents/sentinel events at a minimum, once per quarter during the Agency's Quarterly Quality Meeting and if applicable information should be forwarded to the Governing Body.
2. The agency ownership/designee should notify pertinent authorities as indicated. This includes BrightStar Care Franchise Support Center (e.g. Regional Field Support per the BrightStar Care Reportable Events policy), and may include your state licensing agency and the Joint Commission
3. Incidents requiring reporting to state and/or federal regulatory agencies:
  - a. All regulations and reporting forms will be available in the quality improvement department.
  - b. The agency ownership/designee will review incidents to determine if the event meets reporting criteria.
  - c. As applicable, the agency ownership/designee will complete and submit the necessary forms within the required time frame to the appropriate organization as soon as those agencies' defined guidelines require.
  - d. The agency ownership/designee will prepare and submit any subsequent or summary



- reports that may be required.
- e. Reportable event files will be maintained according to applicable regulations.

## **Sentinel Event Policy Policy No. 4-008**

Events/Incidents that conform to the Joint Commission or BrightStar Care of W. Central Las Vegas's definition of sentinel events will be immediately reported to agency ownership. The agency will conduct a root cause analysis of the sentinel event. The agency ownership/designee will report the sentinel event to Joint Commission in accordance with current Joint Commission policy.

### **SOME EXAMPLES OF SENTINEL EVENTS/OCCURRENCES**

1. Any event or incident which results in the unanticipated death or major permanent loss of function, not related to the natural course of the client's illness or underlying condition e.g. malfunction of a ventilator causing brain injury,
2. 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 a client receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharge from the agency
  - Unanticipated death of a full-term infant
  - Abduction of a client receiving care, treatment, or services
  - Rape - unconsented sexual contact involving a patient and another patient, staff member, or other perpetrator.
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
  - Severe neonatal hyperbilirubinemia (bilirubin > 30 milligrams/deciliter)

## **Root Cause Analysis Policy**

### **Policy No. 4-009**

#### **Policy**

A root cause analysis can be done in conjunction with any quality improvement initiatives including but not limited to the entire quality monitoring program or individual situations that need investigated further. A root cause analysis must be conducted for any sentinel even occurrences. The goal of a root cause analysis is to discover why something has occurred, to look for ways to improvement upon processes, practices or procedures to mitigate future risks of reoccurrence.

#### **Root Cause Analysis**

1. A root cause analysis will be conducted to identify the basic causal factors that underlie variation in performance.
2. The root cause analysis will focus primarily on systems and processes, not individual performance, although individual performance should be factored into the root cause if appropriate based on continued investigation and research.
3. The analysis will progress from special causes in clinical processes, unusual circumstances or events that are difficult to anticipate, to common causes in organization processes. It will identify potential improvement 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.
4. Ordinarily, common cause variation can only be improved by redesigning a process. The intention will be not to accept an event as either human error or equipment breakdown, but to delve into what preceded the event or allowed it to occur.

#### **Action Plan**

1. An action plan will be initiated after the root cause analysis is completed.
2. The action plan will be the product of the root cause analysis, which identifies the strategies the organization intends to implement to reduce the risk of similar events occurring in the future.
3. The action plan must address the following:
  - A. Identification of corrective actions to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors
  - B. Responsibility for implementation
  - C. Timelines for implementation
  - D. Strategies for measuring the effectiveness of the actions

E. Strategies for sustain the change

**Procedure**

**Questions to be asked, including:**

1. What happened?
2. Why did it happen?
3. What processes were involved?
4. What systems underlie these processes?
5. How did the systems or processes fail?
6. Who was involved?

**Process for conducting a root cause analysis:**

1. It is critical that the team understands the purpose of the investigation; keeping in mind that issues obvious to one member may not be to another.
  2. Brainstorming is a good method to find the most likely contributing causes.
  3. Following brainstorming, the team should further assess potential causes.
  4. At this point, the team should begin to determine the cause or causes of the problem and whether it is a special cause or a common cause issue.
  5. It is important that the team not wait to finish the analysis before designing and implementing changes that may be appropriate and necessary to prevent recurrence.
  6. During the process, it is important to determine progress and whether any course adjustments need to be made.
  7. As redesign occurs, there may need to be changes in training, policies, procedures, forms, equipment, etc.
  8. Monitoring for expected results from the redesign should be ongoing but completed no later than six (6) months from interventions.
- 
1. The analysis focuses primarily on systems and processes.
  2. If an individual is identified as the root of the problem the appropriate action steps will be taken under the performance management process not the process improvement initiatives.
  3. The analysis progresses from special causes in clinical processes to common causes in organization processes.

4. The analysis repeatedly digs deeper by asking “Why?”
5. The analysis identifies changes which could be made in systems and processes—either through redesign or development of new systems or processes—that would reduce the risk of such events recurring.
6. The analysis is thorough and credible.

**The root cause analysis is thorough if it includes:**

1. A determination of the precipitating human and other factors most directly associated with the event, and the processes and systems related to its occurrence
2. Analysis of the underlying systems and processes through a series of “Why?” questions to determine where redesign might reduce risk
3. Identification of risk points and their potential contributions to this type of event
4. A determination of potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist

**For the root cause analysis to be credible, it must:**

1. Include participation by the leadership of the organization and by the individuals most closely involved in the processes and systems under review
2. Be internally consistent
3. Provide an explanation for all findings of “not applicable” or “no problem”
4. Include examination of any relevant literature

**An action plan will be considered acceptable if it:**

1. Identifies a resulting action plan that describes the organization’s risk reduction strategies or formulates a rationale for not undertaking such changes, and
2. Identifies who is responsible for implementing improvement actions, when the actions will be implemented (including any pilot testing), and how the effectiveness of the actions will be evaluated

**The organization will:**

1. Document its analysis within 45 days of the event or knowledge of the event, and begin the action plan.
2. Implement the recommended improvements.

3. Monitor the changes for effectiveness.
4. Document its analysis within 45 days of the event or knowledge of the event, and begin the action plan.
5. May provide the root cause analysis and action plan to the Joint Commission within 45 days of the event or knowledge of the event, if requested by the Joint Commission or if the Executive Director/Administrator chooses to self-report the sentinel event.
6. Alternate approaches to the self-disclosure of sentinel event, as described in the Joint Commission Accreditation manual, may be applied, as recommended, to the specific adverse events and organizational leadership concerns.

## Compliance Plan Policy

Policy No. 4-010

### Policy

BrightStar Care of W. Central Las Vegas has established this plan to ensure that quality patient care is provided in a manner that fully complies with all applicable state and federal laws and regulations. It is the policy of BrightStar Care of W. Central Las Vegas that

- (1) all employees are educated about the applicable laws and trained in matters of compliance,
- (2) there is periodic auditing, monitoring and oversight of compliance with those laws,
- (3) there exists an atmosphere that encourages and enables the reporting of non-compliance without fear of retribution,
- (4) responsibility is not delegated to persons with a propensity to act in a non-compliant manner, and
- (5) mechanisms exist to investigate, discipline and correct non-compliance.

The franchise provides for the existence of a Compliance Officer (CO) who has ultimate responsibility and accountability for compliance matters within the franchise.

**However, each individual employee of BrightStar Care of W. Central Las Vegas remains responsible and accountable for his or her own compliance with applicable laws.**

Confirmed acts of non-compliance will be disciplined, including termination.

### Procedure

#### Assignment of Compliance Officer

1. There shall be appointed a Compliance Officer, reporting to the BrightStar Care of W. Central Las Vegas Administrator/CEO and Governing Body.
2. The CO oversees the education of personnel regarding proper compliance, the auditing and monitoring of the statutes of compliance, and the reporting, investigation, discipline and correction of non-compliance. It is also his/her responsibility to ensure programs are in place to guarantee that significant discretionary authority is not delegated to persons with a demonstrated or suspected propensity for improper or unlawful conduct. It is not expected

that the CO will have the knowledge or expertise necessary to ensure compliance with all laws and regulations that affect BrightStar Care of W. Central Las Vegas. He/she is responsible, however, for the overall programs and must ensure that qualified, knowledgeable personnel assist in monitoring and educational functions.

3. The CO reports on the compliance plan to the Quality/ Performance Improvement (QI or PI) or Compliance Committee (at least quarterly) and The Governing Body (at least annually). The report includes but is not limited to:
  - A. The level of compliance or non-compliance found as a result of monitoring and auditing (both internal and external)
  - B. The success of efforts to improve compliance, including training and education
  - C. The non-delegation of discretionary authority to those with the propensity to act improperly
  - D. Corrective or disciplinary action taken with respect to those found to be non-compliant.
4. The CO may appoint such staff as deemed necessary to assist in the performance of the responsibilities outlined above.

## **Employee Reporting**

1. All employees have the responsibility to comply with applicable laws and regulations and to report any acts of non-compliance.
2. Any employee who perceives or learns of an act of non-compliance should either speak to his/her supervisor, call the CO, call the Compliance Hot Line at (insert your number here) or place information in the Compliance lockbox located in an easily accessible area. Supervisors are required to report these issues through established management channels and/or the CO. Reports may be made anonymously, although giving a name and phone number generally makes investigating reports easier and more effective. All employees are encouraged to call the hot line if they have any question about whether their concern should be reported. A written record of every report received will be kept for a period of six (6) years. Every effort will be made to preserve the confidentiality of reports of non-compliance (although calls made anonymously will always preserve the autonomy of the caller). All employees must understand, however, that circumstances may arise in which it is necessary or appropriate to disclose information. In such cases, disclosures will only be made as necessary.
3. All employees are required to report acts of non-compliance. Any employee found to have known of such acts, but who failed to report them, will be subject to discipline.
4. No employee shall, in any way, retaliate against another employee for reporting an act of non-compliance. Acts of retaliation should also be reported to the hot line/lockbox and will be investigated by the CO or his/her designee. Any confirmed act of retaliation shall result in discipline.

## **Investigation of Non-Compliance**



1. The CO or their designee(s) will investigate every report of non-compliance whether reported through the hot line or otherwise. Investigations will be done promptly and will consist of interviewing personnel, examining documents, and consulting with legal counsel, if necessary.
2. The CO or their designee(s) have full authority to interview any employee and review any document (subject to state and federal laws on patient confidentiality) he/she deems necessary to complete the investigation.
3. A written record of each investigation will be created and maintained by the CO. He/she will make every effort to preserve the confidentiality of such records and will make any necessary disclosures on a “need-to-know” basis only.
4. The CO will report the results of each investigation considered significant to the Administrator/CEO. He/she will recommend a course of discipline and/or other corrective action. Sanctions for non-compliance may be imposed.

**Corrective Action or Discipline** (See HR Policy No. 1-025 “Progressive Discipline Policy”)

1. Every confirmed act of non-compliance may result in corrective action or discipline. The sanction for a single act of non-compliance will be decided by the CO. The Administrator/CEO may advise on sanctions for severe or repeated instances of non-compliance. Sanctions may include, but are not limited to, a requirement to follow a certain process or procedure in the future, restitution, and/or discipline including termination.

**Training**

1. The CO will monitor the education of employees concerning the existence of the compliance plan, the contents of the plan, and the need to abide by the specific laws and regulations. The CO will ensure that employees receive a copy of the Standard of Conduct. He/she will inform employees of changes in the laws or regulations periodically and systematically through written communications and in-service training.
2. All current and new employees will have access to the plan. A copy will appear in the Employee Handbook. All new employees will be oriented to the plan and all employees will receive annual inservice training regarding the plan.

**Monitoring and Auditing**

1. The CO and Compliance Committee will conduct an annual risk assessment to identify possible risk areas that need to be addressed by the annual compliance plan. The OIG identified risk areas will be addressed. The CO and Compliance Committee will determine the areas that need continued monitoring and will develop tools to monitor those areas/processes.
2. The CO will be responsible for monitoring employees’ compliance with applicable laws and regulations. He/she will ensure that the level of compliance with the Conditions of

Participation is audited at least annually. He/she will arrange as well for external auditing as deemed necessary.

3. If the CO discovers that a team's/department's or individual's level of compliance is unacceptable, he/she may impose a plan of corrective action, which may include future monitoring of an individual, team/department or specific process on a more frequent basis. Corrective actions and sanction for acts of non-compliance will be managed as outlined previously.
4. Annual audit and monitoring plans will be developed based on topics addressed in the annually published OIG work plan, CMS fraud alerts, previous audit findings and areas identified internally as needing improvement.
  - A. Audit topics may include, but are not limited to:
    1. Signed Bill of Rights
    2. Signed Licensed Prescriber orders
    3. Adherence to plan of care
    4. Home Care Aide supervisor
    5. One-time nursing visit
    6. Therapy utilization
    7. Homebound status
  - B. Billing Accuracy
    1. All claims for services submitted to health care programs for reimbursement will accurately reflect the services ordered and performed. All billing information will be provided to the appropriate payer using accurate information including patient name and address, date(s) of services, date of birth, and service identifiers (CPT-4 codes, HCPCS, Revenue codes or Rate codes).
      - a. Billing Codes (CPT-4, HCPCS, Rate or Revenue Codes) used to bill will accurately describe the service performed and will be payer-specific.
      - b. The Licensed Prescriber's order will not be altered in any manner (increasing or decreasing the number and/or types of services) without the written consent of the ordering Licensed Prescriber.
      - c. Billing Code accuracy is reviewed at the initiation of a service.
      - d. Intentionally or knowingly upcoding a service to maximize reimbursement is forbidden and will result in disciplinary action.

## **Effectiveness of Compliance Program**

1. The effectiveness of the Compliance Program will be evaluated annually and reported to the Governing Body, senior management and all employees. The following will be utilized to determine effectiveness:
  - A. Documentation that employees were adequately trained
  - B. Reports from the hotline, including nature and results of any investigation
  - C. Documentation of corrective action, including disciplinary action taken and policy improvements introduced
  - D. Modifications to the Compliance Program
  - E. Self-disclosures, if applicable

Results of the auditing and monitoring efforts

## **Compliance Officer Policy Policy No. 4-011**

### **Policy**

BrightStar Care of W. Central Las Vegas Governing Body will designate a Compliance Officer (CO) who is responsible for the day to day oversight of the Compliance Plan and coordination of all compliance initiatives.

### **Procedure**

1. The primary duties of the Compliance Officer include, but are not limited to, the following:
  - A. To develop and monitor the implementation of the Compliance Program.
  - B. To develop annual work programs and protocols which address key initiatives to be undertaken based on the organization's policies, perceived areas of risk and governmental focus on compliance issues.
  - C. To periodically review and recommend revising the Compliance Program as necessary to meet the changing needs of the organization in its business and regulatory environment.
  - D. To oversee the coordination of billing, human resources, contracting and other department-specific compliance issues and plans with appropriate senior management to assure compliance with the Compliance Plan and compliance issues.
  - E. To oversee training and monitoring of new and existing employees with the respective education departments or operating departments to assure that employees receive timely and accurate information and sign affirmation statements in a timely manner.
  - F. To oversee that significant outside contractors comply with the organization's Standards of Conduct.
  - G. To oversee compliance with the organization's contracting policies.
  - H. To develop methodologies to address any issues which arise from audits and other oversight measures on a timely basis.
  - I. To assure that monitoring activities are conducted in a non-threatening basis.
  - J. To assure a confidential communications process for solicitation, evaluation and response to complaints and problems (Respond to Hotline issues).

**NEVADA ENDOSCOPY MANAGEMENT, INC  
GASTROENTEROLOGY CONSULTANTS, LTD  
RENO ENDOSCOPY CENTER, LLC  
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**POLICY AND PROCEDURE MANUAL**

**Policy:** Patient Safety Officer and Patient Safety Committee

**Owner:** Center

**Date last updated:** Revised 2/2020

**Purpose:** To ensure the ongoing safety of our patients.

**Patient Safety Officer:** The Manager of Quality Management, shall serve as the Patient Safety Officer. In the event the Manager of Quality Management is not available, the Director of Center Operations shall serve as the Patient Safety Officer. The duties of the Patient Safety Officer include, but are not limited to, the following:

1. Registration with the State of Nevada Health Division "Sentinel Events Registry Contact."
2. Serve on the Patient Safety Committee.
3. Supervise the reporting of all sentinel events alleged to have occurred within the Center to the Nevada State Health Division, pursuant to NRS 439.835.
  - a. The Safety Officer will report to the State within thirteen (13) days of receiving notification, becoming aware or discovering a sentinel event, using the electronic State Report Form.
4. Reviews, investigates and evaluates all sentinel events for cause, trend and prevention.
5. Takes any action necessary to ensure the safety of patients as the result of any review, investigation, and evaluation of all sentinel events.
6. Reports to the Patient Safety Committee all sentinel events and action taken.

**Patient Safety Committee:** The committee shall include the Patient Safety Officer, the RN Director of Center Operations, and the Medical Director/Administrator of the Center. The committee will meet monthly and report to the Center Board of Managers Meeting quarterly. The duties of the Safety Committee will include, but not be limited to:

1. Receive reports from the Patient Safety Officer of all sentinel events.
2. Evaluate the actions of the Patient Safety Officer in connection of all reports of sentinel events.
3. Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.
4. Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections in the facility.
5. 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.
6. At least once each calendar quarter, report to the governing body of the medical facility regarding:
  - a. The number of sentinel events that occurred at the medical facility during the preceding calendar quarter;
  - b. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter;
  - c. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

Approved Board of Managers REC/ SEC 10/11/11; CEC; Approved by Director of Center Ops, QM Manager, and Executive Director 2/14/19

*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.*

- d. Adopt patient safety checklists and patient safety policy; review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Refer to:

- Procedure, Adverse and Sentinel Event Policy
- Patient Safety Policy
- Infection Control Policy
- Nevada Sentinel Events Registry at [http://health.nv.gov/Sentinel\\_Events\\_Registry.htm](http://health.nv.gov/Sentinel_Events_Registry.htm).
- NRS 439.830 – 439.845; 439.875

Approved Board of Managers REC/ SEC 10/11/11; CEC; Approved by Director of Center Ops, QM Manager, and Executive Director 2/14/19

*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.*



# PATIENT SAFETY PLAN

## Carson Tahoe Continuing Care Hospital 2020

*Effective: February 2005 (combines Organization Safety and Patient Safety Plans)*  
*Revised: October, 2005*  
*Revised: December, 2006*  
*Revised: December, 2007*  
*Revised: January, 2009*  
*Revised: January, 2010*  
*Revised: January, 2011*  
*Revised: January, 2012*  
*Revised: February, 2014*  
*Revised: November 2014*  
*Revised: January 2016*  
*Revised: January 2017*  
*Revised: January 2018*  
*Revised: January 2019*  
*Revised: January 2020*

## INTRODUCTION

Carson Tahoe Continuing Care Hospital (CTCCH) is a part of Carson Tahoe Health System, a Nevada not-for-profit hospital. We are committed to patient safety, quality patient care and quality patient outcomes consistent with our Mission and Core Values.

## MISSION

To enhance the health and wellbeing of the communities we serve.

## CORE VALUES

Putting patients first

Treating everyone with dignity and respect.

### I. PURPOSE/ROLE

The purpose of the Patient Safety Committee is to provide vision and direction for patient safety efforts for CTCCH. The Patient Safety Plan provides a systematic approach for continually improving the health and safety of patients who seek care at the medical facility, by encouraging near miss and adverse event reporting; promoting transparency, identifying system flaws and implementing changes to prevent harm to patients, and ensuring clinical services are delivered in compliance with state and federal safety standards.

### II. FRAMEWORK FOR SAFE, RELIABLE AND EFFECTIVE CARE



Supporting the framework are three essential and interrelated domains: leadership, culture and the learning system. Culture is the product of individual and group values, attitudes and competencies, as well as behaviors that form a strong foundation on which the learning system is built. The learning system is characterized by its ability to assess performance. Behaviors such as briefs and de-briefs are examples of reflection and planning forward. At the core of this framework is the engagement of patients, families and staff. The effort involved in fulfilling the framework should be in the service of providing the best outcomes for patients and families and providing an environment that is conducive to



this for staff.

### III. ROLES and RESPONSIBILITIES/COMPOSITION

The Patient Safety Committee shall consist of the System Patient Safety Officer, Infection Control Officer, at least three (3) providers of healthcare, including one medical, one nursing and one pharmaceutical staff, and one member of the executive or governing body. Additional members may include the Quality Director, Chief Medical Officer, VP Legal, Risk and Regulatory Affairs, Environmental Safety Officer, Nursing Director, frontline staff, and ad hoc invitees as appropriate.

### IV. AUTHORITY AND RESPONSIBILITY

The authority and responsibilities of the Committee shall include:

1. Articulate the vision for the Patient Safety Program
2. Define and articulate goals, objectives and performance indicators for each year
3. Oversee and evaluate the trends of patient safety indicators spanning the year
4. Provide structure for coordination and collaboration for patient safety efforts
5. Monitor, communicate and disseminate organizational learning

Committee shall include:

- Infection Control Program to prevent and control infections within the medical facility (this is a document separate from the Patient Safety Plan that meets the requirements for NRS 439.865)
- Patient Safety checklists and patient safety policies as required by NRS. 439.877
- 2020 Checklist Inventory Attachment A
- Annual review and revision of checklists and policies
- Annual Report to Legislative Committee on Health Care
- Integration of all patient safety activities both ongoing and developing
- Ongoing orientation, education and training to emphasize specific job related aspects of patient safety to maintain and improve staff awareness
- Internal reporting of medical / healthcare incidents and events, effectively respond to actual occurrences, manage occurrences and events with a non-punitive approach, and focus on processes and systems to minimize individual blame and retribution
- Periodic survey of the staff regarding willingness to report unsafe conditions, near misses, and adverse events as well as actions taken to prevent recurrence
- Organizational learning and communication of occurrence and event information
- Consideration of patient safety priorities when designing and redesigning of relevant processes, functions and services
- Involvement and education of patients, their families about their role in facilitating safe delivery of care, identifying potential risks and suggesting improvement to patient safety

### V. SCOPE OF ACTIVITIES

The scope of the Patient Safety Plan is organizational-wide which includes but is not limited to:

- Patient Safety
- Visitor Safety
- Employee Safety

The Patient Safety Plan integrates all components of safety in collaboration with Quality, Environmental Safety, Infection Control, Patient Care areas, Risk Management, Compliance and Ethics.

**Patient Safety Committee activities include:**

- Reporting of Sentinel Events pursuant to NRS Chapter 439. Recommendations, as appropriate to the executive or governing body for reducing the number and severity of sentinel events and infections that occur  
Provide emotional support for staff involved in incidents or events, through Human Resources leadership, department supervisors and other resources as appropriate
  - Report at least quarterly to the executive or governing body
    - The number of events by type and severity, including unsafe condition and near miss events
    - The number of sentinel events occurring in the previous quarter
    - The number/severity of infections occurring in the previous quarter
- Quality Measures: Review and evaluate
  - To improve the safety of patients who receive treatment to prevent and control infections
- Monitor patient/ environment safety issues identified throughout the organization
- Promote internal and external knowledge and experience to prevent patient harm, adverse events and occurrences, to maintain and improve patient safety
- Dashboard Trending Report: Review aggregated or trended data including but not limited to: no harm events, mild or moderate adverse outcomes, near misses, medication events, falls, adverse drug reactions, transfusion reactions, and hazardous conditions. Utilize a proactive approach to recognize and acknowledge medical/healthcare events and risks to patient safety, and initiate actions and recommendations to reduce or prevent such events and risks  
Prioritize and recommend Patient Safety activities, as appropriate, utilizing trended data from Environmental Safety, Security, Employee Health, Emergency Management, Lab or Radiation Safety, Utilities Management, Bio Med, Fire Drills or Inspections.
- Identify opportunities and mechanisms to educate and involve patients and families in the patient safety program.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.

**VI.METHODS**

The Root Cause Analysis (RCA) process will be used to determine the contributing and underlying reasons for deficiencies or failures. The Plan-Do-Study-Act (PDSA) methodology is the model for improvement.

A cause and effect diagram, often called a “fishbone” or Ishikawa diagram, is used to brainstorm possible causes of a problem and in sorting ideas into useful causal categories. The problem or effect is displayed at the head or mouth of the fish. Possible causes are listed on the smaller “bones” under various cause categories. A fishbone diagram can be helpful in identifying possible causes for a problem that might not otherwise be considered by directing the team to look at the categories and think of alternative causes. Categories include: Teamwork/Communication, Education/Training, Fatigue/Scheduling, Information Management, Environment/Equipment, and Culture.

Actions are based on the VA National Center for Patient Safety's 'Hierarchy of Actions' and typically include intermediate and stronger actions that require less reliance on humans to remember to perform tasks correctly.

The following sources and criteria will be utilized to identify and prioritize patient safety initiatives:

- Event reports, including unsafe conditions and near misses
- Sentinel Events
- High Volume/Problem Prone processes
- Low Volume/High Risk Problem Prone processes
- Evidence Based Best Practices
- Initiatives consistent with mission, vision, values and strategic direction of facility

#### **PATIENT SAFETY OFFICER**

The Patient Safety Officer is designated by the medical facility and has administrative responsibilities as prescribed by NRS chapter 439 (specifically outlined in NRS 439.815 through NRS.439.875) Duties and responsibilities include but are not limited to:

- Serving on the Patient Safety Committee
- Supervising sentinel event reporting to the State
- Conducting mandatory investigations; assisting with development of actions taken, tracking progress and loop closure with those involved
- Ensuring notification as appropriate within the medical facility

#### **STRUCTURE**

The Quality Reporting Structure Model *Attachment B* visually depicts the reporting structure.

DRAFT

# 2019 Patient Safety Plan Evaluation

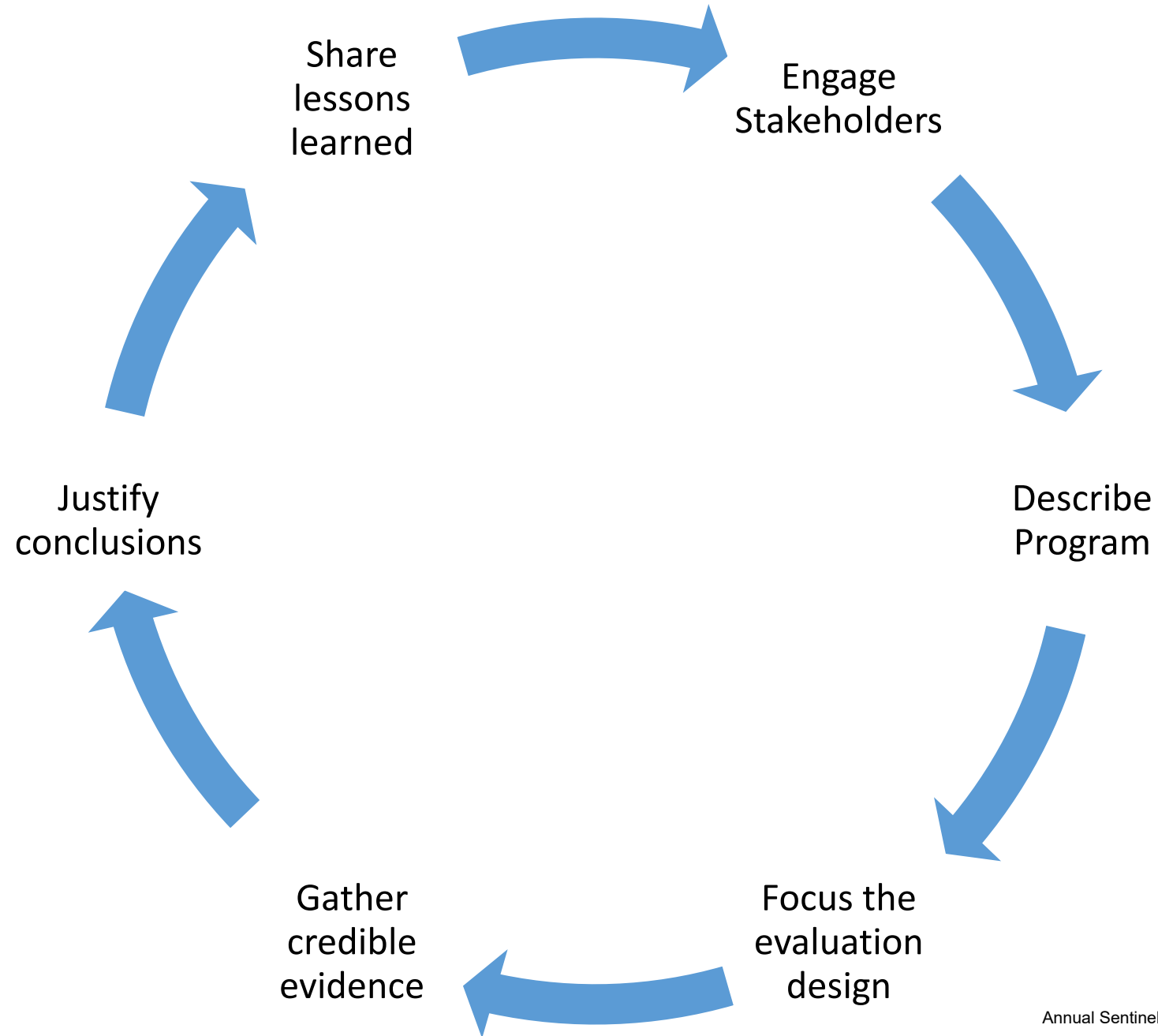
Carson Tahoe Regional Medical Center

Ann McGowan, RN, MSN, CPPS

# Effective Evaluation

- Systematic method to account for and improve actions
- Designed to summarize and organize essential elements
- Comprises steps in effective program evaluation

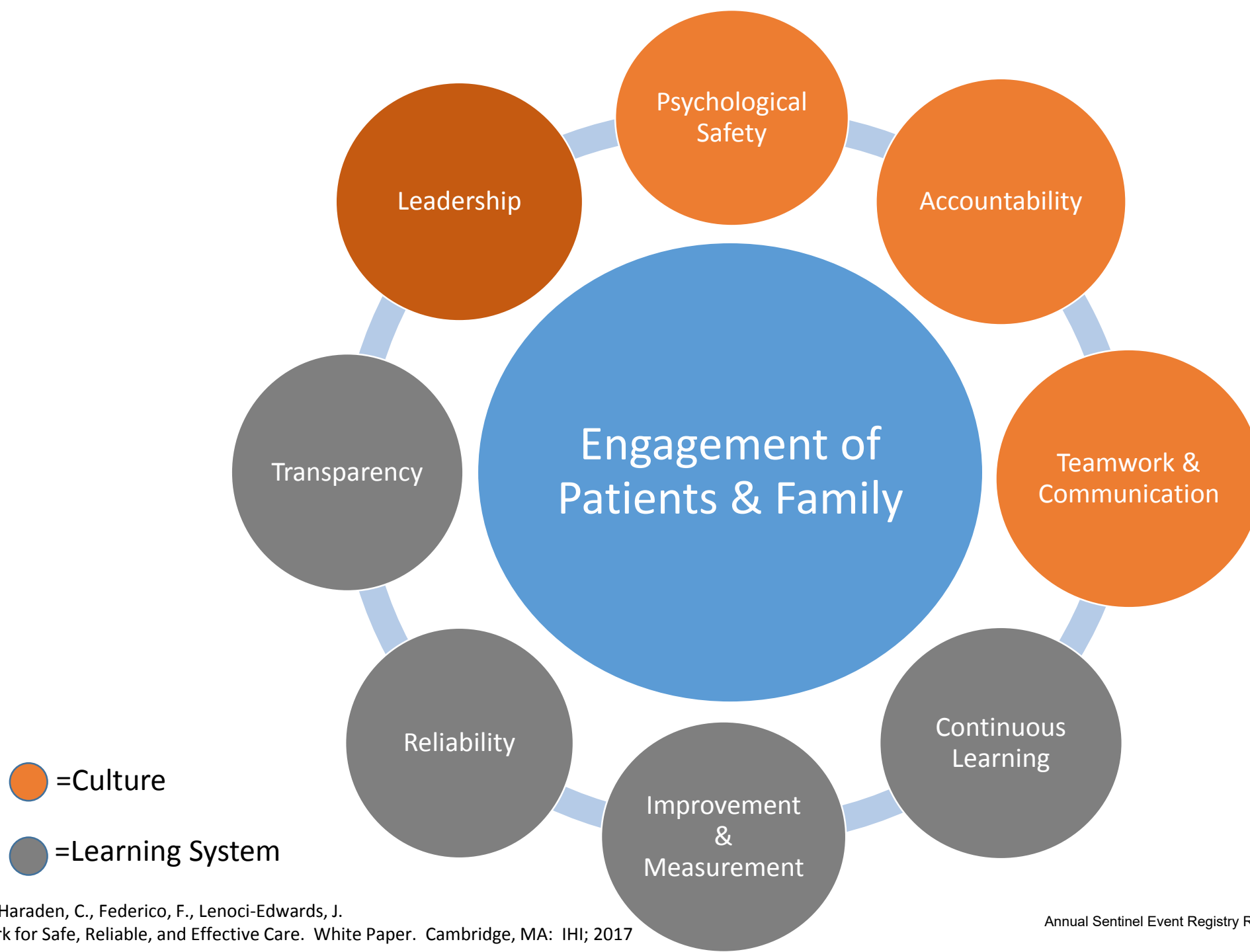
# Framework for Program Evaluation



# Engaging Stakeholders

- Patient Safety Committee membership broadened to include Emergency Department, Education, Surgical Services and Cancer Center
- Patient Safety Committee adopted *A Framework for Safe, Effective, and Reliable Care* (IHI, 2017) as necessary ‘ingredients’ to create a culture of safety and a system for continuous learning





# Description of the Program

The Patient Safety Committee exists in order to provide vision and direction for patient safety efforts.

## 2019 activities included:

Adoption of Patient Safety Committee Charter & Framework to Guide Efforts

Fall Reduction Plan

Encourage near miss and adverse event reporting as part of Medication Safety Plan

Assessment of Patient Safety Culture via Survey on Patient Safety Culture

Implemented 'Good Catch' program

Reengineered Trending Report to make metrics more meaningful

Evaluated and selected RL Datix as the new risk/event reporting, customer experience, and peer review software platform

# Focus Evaluation Design

The Patient Safety Plan evaluation's purpose is to:

1. Gain insight (ex: after testing or implementing an innovative practice)

Assess needs of stakeholders

2. Change practice(s)

Characterize extent to which plans were implemented

Improve content of educational materials

Determine if patient satisfaction rates have improved

3. Assess effects

Decide where to allocate resources

Document level of success in accomplishing objectives

Gather and document success stories

# Evidence, Conclusions and Lessons Learned

# Adult Units Patient Falls Data (excluding L&D and BHS) Dec 2018 – Dec 2019

## 2018

Month - Year	Total Patient Falls	Patient days (IP and OP Obs)	Falls per 1,000 patient days - IP Units	Target = 2.5	Median = 3.07
Jan-18	10	3560	2.81	2.20	3.07
Feb-18	12	2886	4.16	2.20	3.07
Mar-18	11	3374	3.26	2.20	3.07
Apr-18	12	3089	3.88	2.20	3.07
May-18	9	3049	2.95	2.20	3.07
Jun-18	12	3139	3.82	2.20	3.07
Jul-18	8	3074	2.60	2.20	3.07
Aug-18	8	3463	2.31	2.20	3.07
Sep-18	10	3285	3.04	2.20	3.07
Oct-18	13	3334	3.90	2.20	3.07
Nov-18	9	3287	2.74	2.20	3.07
Dec-18	11	3563	3.09	2.20	3.07
<b>TOTAL</b>	<b>125</b>	<b>39103</b>	<b>3.20</b>		3.07

## 2019

Month - Year	Total Patient Falls	Patient days (IP and OP Obs)	Falls per 1,000 patient days - IP Units	Target = 2.5	Median = 2.16
Jan-19	6	3517	1.71	2.50	2.16
Feb-19	4	3356	1.19	2.50	2.16
Mar-19	7	3792	1.85	2.50	2.16
Apr-19	13	3503	3.71	2.50	2.16
May-19	8	3314	2.41	2.50	2.16
Jun-19	4	3275	1.22	2.50	2.16
Jul-19	11	3385	3.25	2.50	2.16
Aug-19	6	3454	1.74	2.50	2.16
Sep-19	8	3255	2.46	2.50	2.16
Oct-19	8	3527	2.27	2.50	2.16
Nov-19	7	3404	2.06	2.50	2.16
Dec-19	10	3595	2.78	2.50	2.16
<b>YTD 2019</b>	<b>92</b>	<b>41377</b>	<b>2.22</b>	<b>2.50</b>	2.16
<b>TOTAL</b>	<b>92</b>	<b>41377</b>	<b>2.22</b>		2.16

CTH serviced 2274 more patients in 2019 than 2018 and had 33 fewer falls. That is a 26.4 % reduction in falls and a met 2019 goal of reducing falls by 20%.

# Falls per 1,000 Patient Days – Adult I/P Units

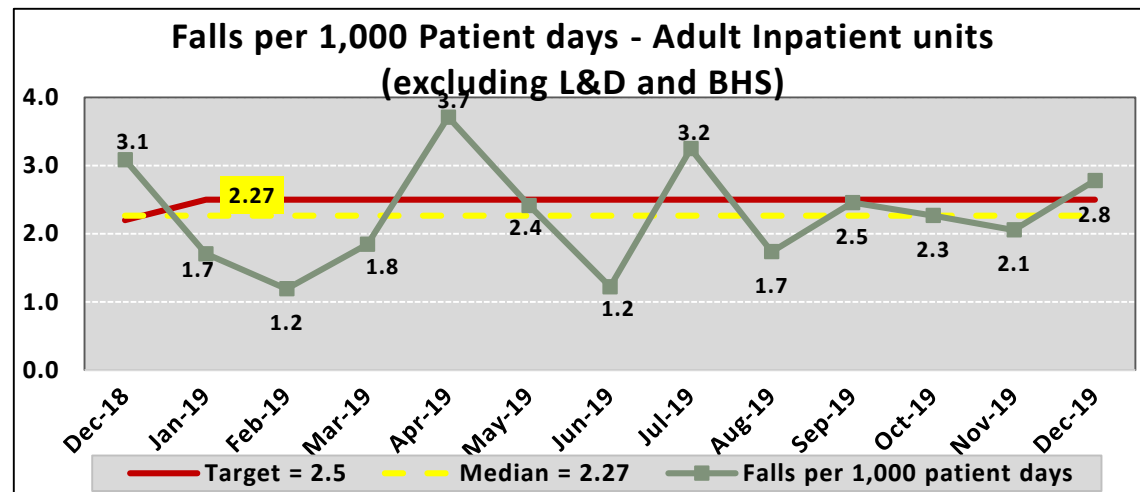
(excluding Labor/Delivery and BHS)

## Measure Description - Target

- Decrease the rate of falls per 1,000 patient days by 20% from a 2018 rate of 3.12 to less than 2.5 by December 2019.
- This is a surveillance measure that tracks the rate of patient falls on adult units which is a validated National Quality Foundation (NQF) metric that is included in the CMS “No Harm Campaign”.
- Target is based on a 20% reduction in falls per the CMS “No Harm Campaign” guidelines.
- N: Total # of patients who fell on Med-Onc, ICU/CVU, SS Post-op, Tele, Med-Onc, Surg-Ortho, ED Obs Unit
- D: Total number of patient days divided by 1,000

## Changes Implemented/Being Tested

- House wide process implementation of “Fall Prevention Deserves Your Attention” Dec 2.
- Fall audits being completed twice a day in all nursing units.
- Patient fall identification signs in use and huddle
- Post Fall Huddle Script finalized, working to make script digital.
- Falls taskforce meets monthly next meeting date of March 19<sup>th</sup>, 2020.



Month - Year	Total Patient Falls	Patient days (IP and OP Obs)	Falls per 1,000 patient days - IP Units	Target = 2.5	Median = 2.27
Dec-18	11	3563	3.09	2.20	2.27
Jan-19	6	3517	1.71	2.50	2.27
Feb-19	4	3356	1.19	2.50	2.27
Mar-19	7	3792	1.85	2.50	2.27
Apr-19	13	3503	3.71	2.50	2.27
May-19	8	3314	2.41	2.50	2.27
Jun-19	4	3275	1.22	2.50	2.27
Jul-19	11	3385	3.25	2.50	2.27
Aug-19	6	3454	1.74	2.50	2.27
Sep-19	8	3255	2.46	2.50	2.27
Oct-19	8	3527	2.27	2.50	2.27
Nov-19	7	3404	2.06	2.50	2.27
Dec-19	10	3595	2.78	2.50	2.27
YTD 2019	92	41377	2.22	2.50	2.27
2018	11	3563	3.09	2.20	2.27
TOTAL	103	44940	2.29		2.27

## Data Analysis – Lessons Learned

- Fall audits showing bed alarms are not properly in place
- Fall audits showing inaccurate use of fall assessment tools
- Increased falls between 1600-1800
- 96% of falls occurring in patient room and bathroom
- 46% of falls patient 6-10 fall risk score.
- 58% of falls related to toileting
- YTD: 2.29
- TARGET: 2.50

## Action Plan

- Quality boards to share data with frontline staff
- Next Falls Agenda :
  - Selection of additional patient fall identifier.
  - Discussion of changes with EPIC
  - ER Falls Presentation
- Long Term: Change to MORSE Fall Scale with implementation of EPIC.

## Team Members

- Executive Sponsor: Anna Anders, RN, VP Nursing
- Champion: Tracey McCollum, RN, Dir Nursing and Ann McGowan, RN, Patient Safety Officer
- Physician Champion: TBD
- Nursing Champion: Danielle Dare, RN, Nurse Supervisor
- Quality Champion: Andrea Travella, RN, Clinical Quality Analyst

	AGREEMENT Our systems/procedures prevent errors	AGREEMENT Safety is never sacrificed to get work done	DISAGREEMENT R-Patient Safety problems exist in this unit	DISAGREEMENT R-By chance, more serious mistakes don't happen
AHRQ Norm	74%	64%	65%	62%
Client Positive Response	67.1%	63.1%	63.4%	59%

There is an increasing body of evidence that links safety culture to higher quality of care and patient outcomes, and a safer work environment.

# LESSONS LEARNED

- Patient Safety framework is comprised of leadership, culture and the learning system. Leaders are guardians of the learning system
- Human Factors: Create systems that help compensate for the limits of the human condition/fallibility
- Move toward involving patients and families
- Meaningful information can help guide interventions. Interventions can reduce adverse outcomes



## Attachment A

Carson Tahoe Regional Medical Center 2020 Checklist Inventory			
Checklist Title		Checklist Category	Department
1	HERT Team Leader Checklist	Other Safety	Emergency Mgt.
2	HERT Activation Checklist	Other Safety	Emergency Mgt.
3	HERT Ambulatory and Non-Ambulatory Set-Up Checklist	Other Safety	Emergency Mgt.
4	HERT Dirty Water Set-up Checklist	Other Safety	Emergency Mgt.
5	HERT Triage/Morgue Set-up Checklist	Other Safety	Emergency Mgt.
6	HERT Tent Set-up Checklist	Other Safety	Emergency Mgt.
7	HERT Receiving Checklist	Other Safety	Emergency Mgt.
8	217 Telemetry, Medical/Oncology & Pharmacy Swing	Environment	Housekeeping
9	304 Projects/Floor Care	Environment	Housekeeping
10	Form 100 Lead/Admin	Environment	Housekeeping
11	Form 101 Telemetry	Environment	Housekeeping
12	Form 102 Medical Oncology A & Pharmacy	Environment	Housekeeping
13	Form 103 Medical Oncology B Therapy Gym	Environment	Housekeeping
14	Form 104 OB/Peds	Environment	Housekeeping
15	Form 105 Surgical/Orthopedics	Environment	Housekeeping
16	Form 106 ICU/CVU	Environment	Housekeeping
17	Form 107 ER/OBS/Fast Track Days	Environment	Housekeeping
18	Form 108 OR Days	Environment	Housekeeping
19	Form 109 Cath Lab/Outpatient Days	Environment	Housekeeping
20	Form 110 Public Area	Environment	Housekeeping
21	Form 111 Waste Management Days	Environment	Housekeeping
22	Form 112 BHS Check Sheet	Environment	Housekeeping
23	Form 113 BHS 'C' Unit	Environment	Housekeeping
24	Form 114 Floor Care	Environment	Housekeeping
25	Form 200 Lead	Environment	Housekeeping
26	Form 202 Tele/OB Swing	Environment	Housekeeping
27	Form 203 Swing Surgical/Orthopedics, CVU and ICU	Environment	Housekeeping
28	Form 204 ICU/CVU Swing	Environment	Housekeeping
29	Form 205 ER/OBS Fast Track Swing	Environment	Housekeeping
30	Form 206 OR Swing	Environment	Housekeeping
31	Form 207 Cath Lab/X-Ray Outpatient	Environment	Housekeeping
32	Form 208 Waste Management Swing	Environment	Housekeeping
33	Form 209 SMC First Floor	Environment	Housekeeping
34	Form 210 Cancer/Merriner	Environment	Housekeeping
35	Form 211 Minden Checklist	Environment	Housekeeping
36	Form 212 Mica Surgery/Pain Clinic	Environment	Housekeeping
37	Form 213 Projects/Floor Care	Environment	Housekeeping
38	Form 214 Projects/Floor Care	Environment	Housekeeping
39	Form 215 Projects/Floor Care	Environment	Housekeeping
40	Form 216 Lab/Office Swing	Environment	Housekeeping
41	Form 217 Telemetry, Med Oncology A and Phm Swing	Environment	Housekeeping
42	Form 301 ER/OBS/Fast Track	Environment	Housekeeping

## Attachment A

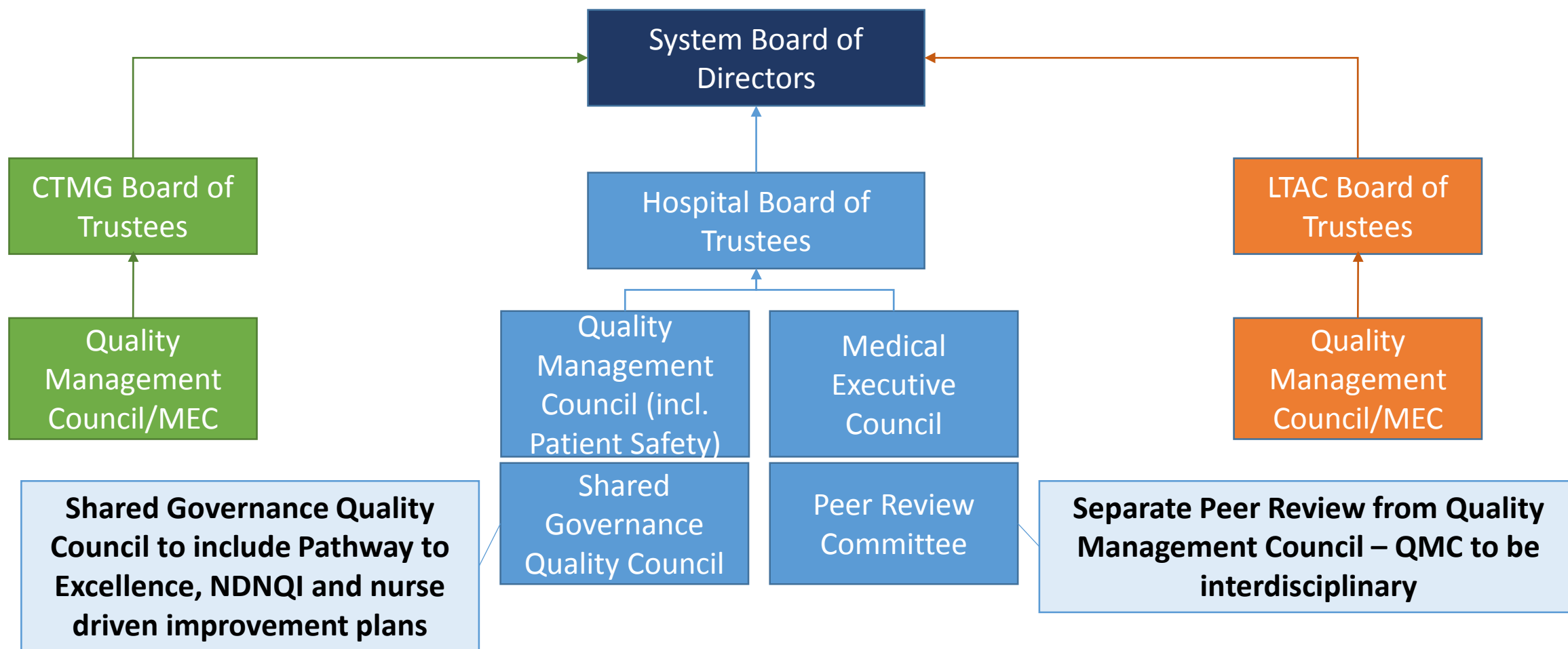
Carson Tahoe Regional Medical Center 2020 Checklist Inventory			
	Checklist Title	Checklist Category	Department
43	Form 302 OR	Environment	Housekeeping
44	Form 303 Basement/Discharges/OR	Environment	Housekeeping
45	Form 304 Projects/Floor Care	Environment	Housekeeping
46	Quality Assurance Checklist	Environment	Housekeeping
47	Pediatric Unit Department Checklist	Environment	PEDS
48	Discharge Checklist for Patients	Discharge	BHS
49	Discharge Checklist for Nursing	Discharge	BHS
50	Admission Checklist Nurse and Tech/Unit Clerk	Other Safety	BHS
51	AMA Intervention Checklist	Other Safety	BHS
52	Shift Checklist for Nursing Staff	Other Safety	BHS
53	Psychosocial Treatment Plan Tracking Form	Treatment	BHS
54	Sharp Contraband Tracking Form	Treatment	BHS
55	Fire Drill Participation	Environment	House wide-Security
56	Fire Report	Environment	Security
57	Fire Watch Form	Environment	Security
58	Life (Fire) Safety Inspection/Business Occupancy	Environment	Security
59	Life (Fire) Safety Inspection/Healthcare Occupancy	Environment	Security
60	Patient Observation Checklist	Other Safety	Security
61	Adult Crash Cart Checklist	Other Safety	House wide
62	Newborn Nursery Crash Cart Checklist	Other Safety	House wide
63	OB Hemorrhage Cart Checklist	Other Safety	House wide
64	Pediatric Crash Cart Checklist	Other Safety	House wide
65	OB Recovery Room Red Cart	Other Safety	House wide
66	OB OR Checklist	Other Safety	Women's/Children
67	3M Steam Flash Sterilization Log	Other Safety	House wide
68	AED Checklist	Other Safety	House wide
69	Breast Milk Refrigerator Temperature Log	Other Safety	Women's/Children
70	Refrigerator/Freezer Temperature Record	Other Safety	House wide
71	List and Process Monitor Documentation System	Other Safety	GBI
72	NV State Immunization Program Temperature Log	Other Safety	Women's/Children
73	Nursery Blanket Warmer Temperature Log	Other Safety	Women's/Children
74	OB/RR Blanket Warmer Temperature Log Top Compartment	Other Safety	House wide
75	Ticket to Ride	Other Safety	House wide
76	Central Line Associated Blood Stream Infection (CLABSI) and Catheter Associated Urinary Tract Infection (CAUTI) surveillance	Other Safety	Infection Control
77	CAUTI Bundle Audit Data Collection	Other Safety	Infection Control
78	Hand Hygiene Compliance Monitoring	Other Safety	Infection Control
79	Infection Control Risk Assessment	Other Safety	Infection Control
80	Emergency Equipment Checklist	Other Safety	ICU
81	Urgent Heart Chart Daily Checklist	Other Safety	ICU

## Attachment A

Carson Tahoe Regional Medical Center 2020 Checklist Inventory			
	Checklist Title	Checklist Category	Department
82	Chemotherapy Administration Checklist	Other Safety	Medical Oncology
83	Pre-Op/Circ/PACU Chart Deficiency Checklist	Treatment	Surgical Areas
84	Hand-off Communication Sheet Pre-Op/OR/PACU	Treatment	Surgical Areas
85	Surgical Checklist	Treatment	Surgical Areas
86	Universal Protocol Checklist/Hand-off Communication	Treatment	Surgical Areas (not SSH)
87	Universal Protocol Checklist for Injection Procedures	Treatment	Surgical Areas (not SSH)
88	Pre-op/Procedural Checklist	Other Safety	Surgical Areas (not SSH)
89	Ventilator Calibration Checklist	Other Safety	Respiratory
90	BHS Unit Safety Rounds Worksheet	Other Safety	House wide
91	Carson Tahoe Emergency Department Triage Protocol	Other Safety	Emergency Dept.
92	Carson Tahoe Emergency Department Stroke Protocol (MD Guidelines)	Other Safety	Emergency Dept.
93	Magnetic Resonance Imaging (MRI) History and Assessment	Treatment	Medical Imaging
94	MRI Invasive Procedure Checklist	Treatment	Medical Imaging
95	Non-Ionic and/or Ionic Contrast Consent Form	Treatment	Medical Imaging
96	Pre-Catheterization/Vascular Lab Checklist	Treatment	Catheterization Lab
97	Patient Room Safety Inspection	Other Safety	House wide
98	Pre-op Education	Treatment	Mica Surgery



# Reporting Structure



# PATIENT SAFETY PLAN

## 2020

*Effective: February 2005 (combines Organization Safety and Patient Safety Plans)*  
*Revised: October, 2005*  
*Revised: December, 2006*  
*Revised: December, 2007*  
*Revised: January, 2009*  
*Revised: January, 2010*  
*Revised: January, 2011*  
*Revised: January, 2012*  
*Revised: February, 2014*  
*Revised: November 2014*  
*Revised: November 2015*  
*Revised: December 2016*  
*Revised: December 2017*  
*Revised: February 2019*  
*Revised: December 2019*

## INTRODUCTION

Carson Tahoe Regional Healthcare/ Regional Medical Center is a part of Carson Tahoe Health System, a Nevada not-for-profit hospital. We are committed to patient safety, quality patient care and quality patient outcomes consistent with our Mission and Core Values.

## MISSION

To enhance the health and wellbeing of the communities we serve.

## CORE VALUES

Putting patients first

Treating everyone with dignity and respect.

### I. PURPOSE/ROLE

The purpose of the Patient Safety Committee is to provide vision and direction for patient safety efforts for the Regional Medical Center. The Patient Safety Plan provides a systematic approach for continually improving the health and safety of patients who seek care at the medical facility, by encouraging near miss and adverse event reporting; promoting transparency, identifying system flaws and implementing changes to prevent harm to patients, and ensuring clinical services are delivered in compliance with state and federal safety standards.

### II. FRAMEWORK FOR SAFE, RELIABLE AND EFFECTIVE CARE



Supporting the framework are three essential and interrelated domains: leadership, culture and the learning system. Culture is the product of individual and group values, attitudes and competencies, as well as behaviors that form a strong foundation on which the learning system is built. The learning system is characterized by its ability to assess performance. Behaviors such as briefs and de-briefs are examples of reflection and planning forward. At the core of this framework is the engagement of patients, families and staff. The effort involved in fulfilling the framework should be in the service of providing the best outcomes for patients and families and providing an environment that is conducive to this for staff.

### **III. ROLES and RESPONSIBILITIES/COMPOSITION**

The Patient Safety Committee shall consist of the System Patient Safety Officer, Infection Preventionist, at least three (3) providers of healthcare, including one medical, one nursing and one pharmaceutical staff, and one member of the executive or governing body. Additional members may include the Quality Director, Chief Medical Officer, Environmental Safety Officer, Nursing Director, frontline staff, and ad hoc invitees as appropriate.

### **IV. AUTHORITY AND RESPONSIBILITY**

The authority and responsibilities of the Committee shall include:

1. Articulate the vision for the Patient Safety Program
2. Define and articulate goals, objectives and performance indicators for each year
3. Oversee and evaluate the trends of patient safety indicators spanning the year
4. Provide structure for coordination and collaboration for patient safety efforts
5. Monitor, communicate and disseminate organizational learning

Committee shall include:

- Infection Prevention Program to prevent and control infections within the medical facility (this is a document separate from the Patient Safety Plan that meets the requirements for NRS 439.865)
- Patient Safety checklists and patient safety policies as required by NRS. 439.877
- 2020 Checklist Inventory *Attachment A*
- Annual review and revision of checklists and policies
- Annual Report to Legislative Committee on Health Care
- Integration of all patient safety activities both ongoing and developing
- Ongoing orientation, education and training to emphasize specific job related aspects of patient safety to maintain and improve staff awareness
- Internal reporting of medical / healthcare incidents and events, effectively respond to actual occurrences, manage occurrences and events with a non-punitive approach, and focus on processes and systems to minimize individual blame and retribution
- Periodic survey of the staff regarding willingness to report unsafe conditions, near misses, and adverse events as well as actions taken to prevent recurrence
- Organizational learning and communication of occurrence and event information
- Consideration of patient safety priorities when designing and redesigning of relevant processes, functions and services
- Involvement and education of patients, their families about their role in facilitating safe delivery of care, identifying potential risks and suggesting improvement to patient safety

### **V. SCOPE OF ACTIVITIES**

The scope of the Patient Safety Plan is organizational-wide which includes but is not limited to:

- Patient Safety
- Visitor Safety
- Employee Safety

The Patient Safety Plan integrates all components of safety in collaboration with Quality, Environmental Safety, Infection Prevention, Patient Care areas, Risk Management, Compliance and Ethics.

**Patient Safety Committee activities include:**

- Performing analysis of patient safety event data in order to identify trends and system issues for use in decision-making and identification of improvement opportunities
- Participating in standardizing work and designing processes consistent with the science of patient safety
- Reporting of Sentinel Events pursuant to NRS Chapter 439.
- Recommendations, as appropriate to the executive or governing body for reducing the number and severity of sentinel events and infections that occur
- Providing emotional support for staff involved in incidents or events, through Human Resources leadership, department supervisors and other resources as appropriate
  - Report at least quarterly to the executive or governing body
    - The number of events by type and severity, including unsafe condition and near miss events
    - The number of sentinel events occurring in the previous quarter
    - The number/severity of infections occurring in the previous quarter
- Quality Measures: Review and evaluate to improve the safety of patients who receive treatment to prevent and control infections
- Monitor patient/ environmental safety issues identified throughout the organization
- Promote internal and external knowledge and experience to prevent patient harm, adverse events and occurrences, to maintain and improve patient safety
- Dashboard Trending Report: Review aggregated or trended data including but not limited to: no harm events, mild or moderate adverse outcomes, near misses, medication events, falls, adverse drug reactions, transfusion reactions, and hazardous conditions. Utilize a proactive approach to recognize and acknowledge medical/healthcare events and risks to patient safety, and initiate actions and recommendations to reduce or prevent such events and risks  
Prioritize and recommend Patient Safety activities, as appropriate, utilizing trended data from Environmental Safety, Security, Employee Health, Emergency Management, Lab or Radiation Safety, Utilities Management, Bio Med, Fire Drills or Inspections.
- Identify opportunities and mechanisms to educate and involve patients and families in the patient safety program

**VI.METHODS**

The Root Cause Analysis (RCA) process will be used to determine the contributing and underlying reasons for deficiencies or failures. The Plan-Do-Study-Act (PDSA) methodology is the model for improvement.

A cause and effect diagram, often called a “fishbone” or Ishikawa diagram, is used to brainstorm possible causes of a problem and in sorting ideas into useful causal categories. The problem or effect is displayed at the head or mouth of the fish. Possible causes are listed on the smaller “bones” under various causal categories. A fishbone diagram can be helpful in identifying possible causes of a problem that might not otherwise be considered by directing the team to look at the categories and think of alternative causes. Categories include: Teamwork/Communication, Education/Training, Fatigue/Scheduling, Information Management, Environment/Equipment, and Culture.



Actions are based on the VA National Center for Patient Safety's 'Hierarchy of Actions' and typically include intermediate and stronger actions that require less reliance on humans to remember to perform tasks correctly.

Failure Modes and Effects Analysis (FMEA) is a team-based, systematic, *proactive* technique used to prevent problems before they occur. FMEA analyzes potential failures of systems, components, or functions and their effects. It provides a view of not only what problems can occur, but also the severity of such problems.

The following sources and criteria will be utilized to identify and prioritize patient safety initiatives:

- Event reports, including unsafe conditions and near misses
- Sentinel Events
- High Volume/Problem Prone processes
- Low Volume/High Risk Problem Prone processes
- Evidence Based Best Practices
- Initiatives consistent with mission, vision, values and strategic direction of facility

#### **PATIENT SAFETY OFFICER**

The Patient Safety Officer is designated by the medical facility and has administrative responsibilities as prescribed by NRS chapter 439 (specifically outlined in NRS 439.815 through NRS.439.875) Duties and responsibilities include but are not limited to:

- Serving on the Patient Safety Committee
- Supervising sentinel event reporting to the State
- Conducting mandatory investigations; assisting with development of actions taken, tracking progress and loop closure with those involved
- Ensuring notification as appropriate within the medical facility

#### **STRUCTURE**

*Attachment B* depicts the reporting structure.

**Centennial Hills Hospital Medical Center**

# **Risk Management/ Patient Safety Plan**

**Nevada Acute Care Division**

Revised 1/2020

## I. Overview

Centennial Hills Hospital endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. Centennial Hills Hospital operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that Centennial Hills Hospital remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by Centennial Hills Hospital to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan ("Plan") provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at Centennial Hills Hospital. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the "Just Culture" concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with Centennial Hills Hospital policies. Centennial Hills Hospital employees, contractors, vendors, and members of each facility's medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

### GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

## **II. Mission and Vision**

Centennial Hills Hospital's mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

Centennial Hills Hospital recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

## **III. ROLES AND RESPONSIBILITIES**

### **A. Risk Management/Patient Safety Officer**

Centennial Hills Hospital has a designated Risk Director/Manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk



Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) include:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

## **B. Infection Control Officer**

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee.
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the Patient Safety Plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a Certified Infection Preventionist.

### **C. Patient Safety**

Centennial Hills Hospital has an established Patient Safety Council (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. Centennial Hills Hospital has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to RiskConnect (STARS) and Midas) to maintain and manage PSWP.

#### **I. Facility Patient Safety Committee**

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully. Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

#### **Membership:**

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF)) of the medical facility.

#### **Meetings:**

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.



**Duties and Responsibilities:**

Centennial Hills Hospital's PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the Patient Safety Checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.

- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:

(1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

(2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt Patient Safety Checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, The Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

## **II. Patient Safety Advisories**

When an untoward event occurs at the facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, Safety Watch newsletters are distributed. These alerts detail the circumstances that lead to a negative outcome and the facility is charged with assessment and improvement of their own processes to prevent similar occurrences. In addition, Clinical Risk Alerts and Medication Safety Alerts are also formulated to apprise the facilities of a specific safety issue that needs to be assessed to prevent reoccurrence.

Centennial Hills Hospital is required to address the Safety Watch newsletters, Clinical Risk Alerts and Medication Safety Alerts via their Patient Safety Committee and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

## **C. TERM Program**

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate



organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

**Element I. Administration of the Risk Management Program:** The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

**Element II. Risk Identification:** Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

**Element III. Risk Education:** Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

**Element IV. Patient Safety Initiative:** Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC). The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

**Element V. Patient Safety Priority: Root Cause Analysis (RCA):** The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

**Element VI. Environment of Care; Safety and Security Programs:** The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

**Element VII. Claims and Litigation Management:** The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

**Element VIII. Patient Safety Organization (PSO):** Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their

responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

#### **D. MIDAS**

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

#### **E. Risk Connect (STARS)**

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by Centennial Hills Hospital's RM to the Governing Board of all claims activities.

#### **F. Event Notification Site**

The Event Notification Site or ENS, is a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and



stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

### **G. Root Cause Analysis (RCA)**

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

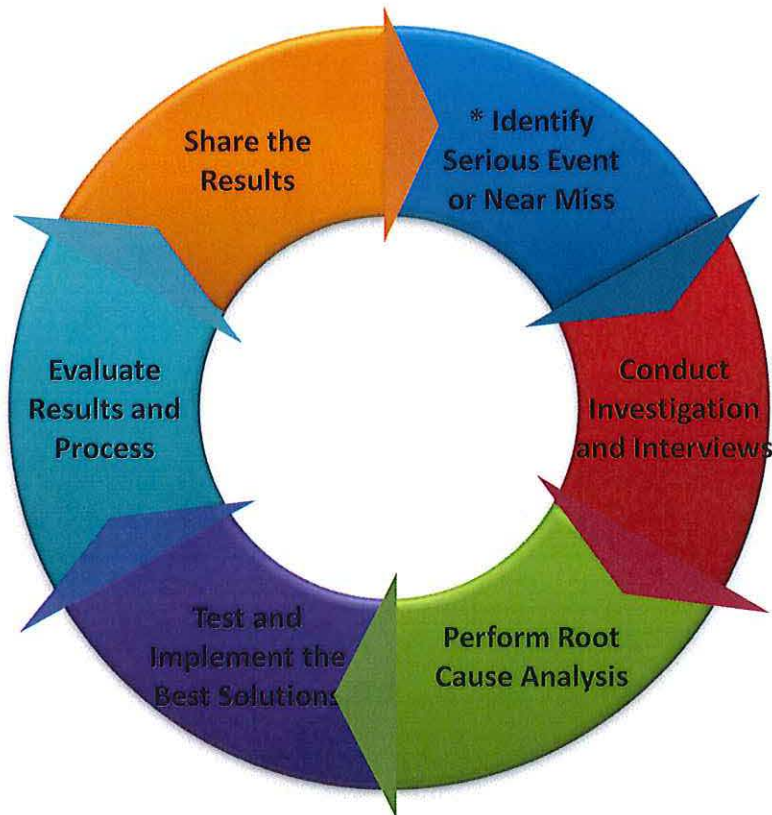
A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that The Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

#### **RCA Responsibilities**

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



#### H. Patient Safety Checklists

By [NRS 439.865](#), the Patient Safety Plan must include the Patient Safety Checklists and Patient Safety Policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Patient Safety Checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

(For your reference— a checklist example is shown in **Appendix A.**)

## **I. Patient Safety Policies**

The Patient Safety Policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

## **J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)**

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and



state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

## K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired Risk Directors/Managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each Risk Director/Manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories
- Clinical Risk Alerts
- Medication Safety Alerts

## IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2020

- Surgical and Procedural Safety:
  - **Wrong Site Surgery (WSS).**
    - **Goal:** A 50% reduction in WSS events for 2020. Ultimately the goal is zero (0).
      - Monitor through Midas event reporting. Report monthly.
  - **Retained Procedural items (RPIs)**
    - **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2020. Ultimately the goal for RPIs is 0.
      - Monitor through Midas event reporting. Report monthly.
- **OBHRU:**
  - **Reduction/Elimination of serious harm by reducing the response time to adverse obstetrical bleeding initiative.**

- **Goal:** As evidenced by:
  - Education Module X: All new hire staff and providers to complete Hemorrhage module within 1st 3 months of employment. All current staff and providers who care for perinatal patients to complete Hemorrhage module every 2 years (even years).
  - Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results of Power Insights Hemorrhage report/dashboard.
  - All patients will receive POST BIRTH warning signs education for inpatient stay and discharge as evidenced by Power Insights report on education completion.
  - POST BIRTH collaborative benchmarking and assessment data from AWHONN/Premier collaborative.
- Monitor through Powers Insights QBL compliance report/Midas/ENS/Claims data, GNOSIS results, and facility education reports. Report monthly.
- **CLABSI/CAUTI Initiative**
  - **Goal:** CLABSI and CAUTI will both be reduced to less than the National CMS mean Standardized Infection Ratio (SIR: CLABSI 0.783; CAUTI 0.857) in 2020.
  - Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly.
- **Safe Medication Use**
  - Opioid Analgesic Event Reduction Initiative
    - **Goal:** Decrease the number of preventable OIRD events by 10%.
  - Monitor through MIDAS reports, Cerner, ICD-10 Codes, and other intervention data. Report monthly.
- **Reduce Falls and Falls with Injury**
  - **Goal:** 10 % overall reduction in the number of falls in the facility by end of 2020.
  - Review of the progressive mobility (PM) documentation in the facility.
  - Correlation of PM documentation and fall incidents.
  - Review of the documentation of PM in the ICU with LOS and length of intubation.
  - Review of documentation of mobility and progression of mobility.
  - Monitor through MIDAS event reporting. Report quarterly.

- **Culture of Safety**
  - **Goal:** 100% of 2020 Patient Safety Plan Priorities will be implemented within the facility.
  - Monitor through MIDAS event reporting with monthly reporting to PSC.
- **Centennial Hills Hospital Focus Goals for 2020**
  - Zero Retained Procedural Items
  - 20% decrease in inpatient falls
  - 50% decrease in toileting related falls
  - 50% decrease in medication Pyxis overrides
  - 95% compliance with Manager RDE completion

## **V. Monitoring and Accountability**

### **A. Evaluation of TERM Program**

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

### **B. Patient Safety Committee**

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed and detailed feedback is provided to coach the committee on their form and function.

### **C. Dashboards**

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure.

## **VI. Evaluation/Review:**

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of "Near Miss" events



- The framework advances a “Just Culture” approach to patient safety
- Accountability is promoted when acts of “human error”, “at risk”, or “reckless behavior” are identified and corrected resulting in a reduction of potential/actual adverse outcomes.
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

## VII. Confidentiality

All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities. The PSC annually reviews the effectiveness of the Safety Plan to ensure goals and objectives are appropriately focused on improving patient safety.

## VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the Governing Board of the facility for approval. After a facility’s patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The Patient Safety Plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current Patient Safety Plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

## Appendix A: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls				
Prevention from PT, OT, MD, RN and Phar.D.				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

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## I. PURPOSE

The purpose of the organizational Patient Safety Plan at the hospital is to improve patient safety and reduce risk to patients through an environment that encourages:

- Integration of safety priorities into all relevant organization processes, functions, services, departments and programs
- Recognition and acknowledgment of risks to patient safety and medical/health care errors
- The initiation of actions to reduce these risks
- The internal and external reporting of what has been found and the actions taken
- A focus on processes and systems, and the reduction of process and system failures through use of failure mode effect analysis
- Minimization of individual blame or retribution for involvement in a medical/health care error
- Organizational learning about medical/health care errors
- Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations
- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to potential or actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.
- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at the hospital. The Patient Safety Plan, developed by the interdisciplinary Safety/Environment of Care Committee

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and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

## II. PATIENT SAFETY PLAN

- Scope of Activities:
  - The scope of the Patient Safety Plan includes ongoing proactive risk assessments, using internal and external knowledge and experience, to prevent error occurrence, maintain, and improve patient safety.
  - Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis, maybe, but not limited to:
    - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.
    - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
    - Any Medication Variance
    - Any Adverse Drug Reaction
    - Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
  - Sentinel Event: The following events as outlined on NQF Serious Reportable Events in Healthcare:

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- Surgical Invasive Procedure Events
- Product or Device Events
- Patient Protection Events
- Radiologic Events
- Care Management Events
- Environmental Events
- Potential Criminal Events
- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.
- Hospital Acquired Conditions (HACs):
  - a. Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, other injuries)
- The scope of the Patient Safety Plan encompasses the patient population, visitors, volunteers, and staff (including medical staff). The plan addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:
  - Environment of Care
  - Emergency Management
  - Human Resources
  - Infection Prevention and Control
  - Information Management
  - Leadership

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- Life Safety
- Medication Management
- Medical Staff
- Nursing
- Provision of Care, Treatment and Services
- Performance Improvement
- Record of Care, Treatment and Services
- Rights and Responsibilities of the Individual
- Waived Testing

#### Methodology:

- The Interdisciplinary Safety/Environment of Care Committee is responsible for the oversight of the Patient Safety Plan. The Safety/Environment of Care Committee Chairperson will have administrative responsibility for the plan, or the Safety/Environment of Care Committee may assign this responsibility to another member of the committee.
- All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Director PI/Risk Management, who will aggregate occurrence information and present a report to the Safety/Environment of Care Committee. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety/Environment of Care Committee will analyze the report information and determine further patient safety activities as appropriate.
- Through review of internal data reports and reports from external sources (including, but not limited to, sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from state and federal sources

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and current literature), and through the performance improvement priority criteria grid, the Safety/Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually. All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams). The proactive risk assessment will include:

- Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be
- Prioritizing the potential processes breakdowns or failures
  - For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
  - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
  - Test and implement the redesigned process
  - Identify and implement measures of the effectiveness of the redesigned process
  - Implement a strategy for maintaining the effectiveness of the redesigned process over time
- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organizationwide program.
- 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.



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- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.

Preserve any information related to the error (including physical information). Examples of preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.

- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.
- Submit the occurrence report to the Performance Improvement Department per organizational policy.
- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his/her supervisor and document the findings on an incident report. The report will be submitted to the Director PI/Risk Management per organizational policy.
- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:
  - No Harm Failures or Errors (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.
  - Mild-Moderate Adverse Outcome Failures or Errors (including medication errors/variances) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the PI/Risk Management Department per organizational policy.



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- Medication Variances/errors - the staff member identifying a medication variance/error (no harm and mild-moderate harm) will notify the Pharmacy Department of the event.
- Adverse Drug Reaction (ADR) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report, submitting the report to the PI/Risk Management Department. Staff will complete ADR report and forward to Pharmacy.
- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his/her supervisor and document the findings on an incident report. The report will be submitted to the PI/Risk Management Department per organizational policy.
- Sentinel Event - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.
- Near Miss - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an incident report and submit the report to the PI/Risk Department.
- Hospital Acquired Conditions - staff will follow all established protocols, guidelines and policies and procedures. Staff shall complete incident reports for any breaks in technique or policy not followed.

Established organizational policy (such as the Sentinel Event Policy) and/or the Safety/Environment of Care Committee will determine the organizational response to process/system failures and/or medical/health care errors and occurrences. All sentinel events and near miss occurrences will have a root cause analysis conducted. The determination of the Safety/Environment of Care Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:

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- 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 Plan cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences. All staff is required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Safety/Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.
- Sentinel Events - staff members involved in a sentinel event occurrence will receive support from the Safety/Environment of Care Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Safety/Environment of Care Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Service Department, Human Resources Department and/or his/her department supervisor.

As part of this organization's culture of safety and quality, any staff member who has concerns about the safety or quality of care provided by the organization may report these concerns to their accrediting organization. The organization supports the staff member's right to report these concerns and will take no disciplinary or retaliatory action against the staff member for reporting the safety or quality of care concern to their accrediting organization.

- On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.

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- The Patient Safety Plan includes implementation of the recommendations set forth by the accrediting organization, or identified alternative recommendations defined by this institution, to achieve compliance with established safety standards. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified safety standards.
- The Patient Safety Plan includes an annual survey of staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.
- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Safety/Environment of Care Committee will analyze error reporting data submitted through the PI/Risk Management Department for evidence of this information.

Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care.

The Patient Safety Plan includes consideration, at least annually, of data obtained from the organizational Information Management Needs Assessment, which includes information regarding barriers to effective communication among caregivers.

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. Education includes the staff member's right to report any safety or quality of care concerns to the organization's accrediting organization. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.
- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.
- Lessons learned from a root cause analysis shall be communicated to staff who provide services or are affected by a patient safety incident

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- Patient safety reports from the Safety/Environment of Care Committee will be submitted to the organizational Quality, which exists as the oversight committee for the Safety/Environment of Care Committee. A data report and recordings of meeting minutes will be forwarded to the Quality Committee.

A written Patient Safety Report shall be forwarded to the Governing Body, at a minimum, once per year. Information in the report shall include:

- All system or process failures
- Number and type of sentinel events
- If patients and families were informed of the adverse events
- All actions taken to improve safety, both proactively and in response to actual occurrences
- All results of the analyses related to the adequacy of staffing and actions taken to resolve the identified problem(s)

**Desert Springs Hospital Medical Center**

# **Risk Management/ Patient Safety Plan**

**Nevada Acute Care Division**



Revised 1/2020

## I. **Overview**

Desert Springs Hospital Medical Center endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients. Patient safety is a cornerstone of quality care and is a leadership priority. Desert Springs Hospital Medical Center operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that Desert Springs Hospital Medical Center remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by Desert Springs Hospital Medical Center to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at Desert Springs Hospital Medical Center. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with Desert Springs Hospital Medical Center policies. Desert Springs Hospital Medical Center employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

### **GENERAL STATEMENTS ON GOALS AND OBJECTIVES**

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

## II. Mission and Vision

Desert Springs Hospital Medical Center's mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

Desert Springs Hospital Medical Center recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

## III. ROLES AND RESPONSIBILITIES

### A. Risk Management/Patient Safety Officer

Desert Springs Hospital Medical Center has a designated Risk Director responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk Director is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) include:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

## **B. Infection Control Officer**

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee.
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the Patient Safety Plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World



Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a Certified Infection Preventionist.

## **C. Patient Safety**

Desert Springs Hospital Medical Center has an established Patient Safety Council (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. Desert Springs Hospital Medical Center has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to RiskConnect (STARS) and Midas) to maintain and manage PSWP.

### **I. Facility Patient Safety Committee**

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully. Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

#### **Membership:**

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

## Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

## Duties and Responsibilities:

Desert Springs Hospital Medical Center's PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the Patient Safety Checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.

- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt Patient Safety Checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, The Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

## **II. Patient Safety Advisories**

When an untoward event occurs at the facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, Safety Watch newsletters are distributed. These alerts detail the circumstances that lead to a negative outcome and the facility is charged with assessment and improvement of their own processes to prevent similar occurrences. In addition, Clinical Risk Alerts and Medication Safety Alerts are also formulated to apprise the facilities of a specific safety issue that needs to be assessed to prevent reoccurrence.

Desert Springs Hospital Medical Center is required to address the Safety Watch newsletters, Clinical Risk Alerts and Medication Safety Alerts via their Patient Safety Committee and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

## C. TERM Program

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

**Element I. Administration of the Risk Management Program:** The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

**Element II. Risk Identification:** Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

**Element III. Risk Education:** Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

**Element IV. Patient Safety Initiative:** Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC). The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

**Element V. Patient Safety Priority: Root Cause Analysis (RCA):** The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

**Element VI. Environment of Care; Safety and Security Programs:** The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

**Element VII. Claims and Litigation Management:** The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

**Element VIII. Patient Safety Organization (PSO):** Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

#### **D. MIDAS**

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

#### **E. Risk Connect (STARS)**

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by Desert Springs Hospital Medical Center's RM to the Governing Board of all claims activities.

## F. Event Notification Site

The Event Notification Site or ENS, is a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

## G. Root Cause Analysis (RCA)

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that The Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

### RCA Responsibilities

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



#### H. Patient Safety Checklists

By [NRS 439.865](#), the Patient Safety Plan must include the Patient Safety Checklists and Patient Safety Policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Patient Safety Checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

(For your reference— a checklist example is shown in **Appendix A.**)

## **I. Patient Safety Policies**

The Patient Safety Policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

## **J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)**

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of



PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

## K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired Risk Directors/Managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each Risk Director/Manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories
- Clinical Risk Alerts
- Medication Safety Alerts

## IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2020

- Surgical and Procedural Safety:
  - **Wrong Site Surgery (WSS).**
    - **Goal:** A 50% reduction in WSS events for 2020. Ultimately the goal is zero (0).
      - Monitor through Midas event reporting. Report monthly.
  - **Retained Procedural items (RPIs)**
    - **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2020. Ultimately the goal for RPIs is 0.
      - Monitor through Midas event reporting. Report monthly.

- **CLABSI/CAUTI Initiative**
  - **Goal:** CLABSI and CAUTI will both be reduced to less than the National CMS mean Standardized Infection Ratio (SIR: CLABSI 0.783; CAUTI 0.857) in 2020.
  - Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly.
- **Safe Medication Use**
  - Opioid Analgesic Event Reduction Initiative
    - **Goal:** Decrease the number of preventable OIRD events by 10%.
    - Monitor through MIDAS reports, Cerner, ICD-10 Codes, and other intervention data. Report monthly.
  - MIDAS Medication Event Reporting
    - **Goal:** Maintain monthly reporting of Medication Events to at least 15% Medication Events/1000 Actual Patient Days
    - Monitor through MIDAS. Report monthly with oversight by PSC.
- **Reduce Falls and Falls with Injury**
  - **Goal:** 10 % overall reduction in the number of falls in the facility by end of 2020.
  - Review of the progressive mobility (PM) documentation in the facility.
  - Correlation of PM documentation and fall incidents.
  - Review of the documentation of PM in the ICU with LOS and length of intubation.
  - Review of documentation of mobility and progression of mobility.
  - Monitor through MIDAS event reporting. Report quarterly.
- **Culture of Safety**
  - **Goal:** 100% of 2020 Patient Safety Plan Priorities will be implemented within the facility.
  - Monitor through MIDAS event reporting with monthly reporting to PSC.

## V. Monitoring and Accountability

### A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

## **B. Patient Safety Committee**

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed and detailed feedback is provided to coach the committee on their form and function.

## **C. Dashboards**

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure.

## **VI. Evaluation/Review:**

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of "Near Miss" events
- The framework advances a "Just Culture" approach to patient safety
- Accountability is promoted when acts of "human error", "at risk", or "reckless behavior" are identified and corrected resulting in a reduction of potential/actual adverse outcomes.
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action
- Review of annualized and prior year's probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

## **VII. Confidentiality**

All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities. The PSC annually reviews the effectiveness of the Safety Plan to ensure goals and objectives are appropriately focused on improving patient safety.

## VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the Governing Board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The Patient Safety Plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current Patient Safety Plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

### Appendix A: Checklist Example: Injuries from Falls and Immobility

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)				

<b>Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds</b>				
<b>Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives</b>				
<b>Incorporate multidisciplinary input for falls</b>				
<b>Prevention from PT, OT, MD, RN and Phar.D.</b>				
<b>Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient</b>				
<b>Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls</b>				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

**Desert View Hospital**

# **Risk Management/ Patient Safety Plan**

**Nevada Acute Care Division**

Revised 1/2020

## I. Overview

**XXX Hospital** endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. **XXX Hospital** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **XXX Hospital** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **XXX Hospital** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan ("Plan") provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **Desert View Hospital**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the "Just Culture" concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **Desert View Hospital** policies.

**Desert View Hospital** employees, contractors, vendors, and members of each facility's medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

### GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

## II. Mission and Vision

**Desert View Hospital's** mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

**Desert View Hospital** recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

## III. ROLES AND RESPONSIBILITIES

### A. Risk Management/Patient Safety Officer

**Desert View Hospital** has a designated Risk Director/Manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk



Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

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- Serving on the Patient Safety Committee (PSC)
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- Reporting to the PSC concerning the number and severity of infections at the facility each month.
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- Facility-specific infection control developed under the supervision of a Certified Infection Preventionist.

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**Desert View Hospital** has an established Patient Safety Council (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **Desert View Hospital** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to RiskConnect (STARS) and Midas) to maintain and manage PSWP.

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According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully. Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

#### Membership:

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#### Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

**Duties and Responsibilities:**

**Desert View Hospital's** PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the Patient Safety Checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.

- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt Patient Safety Checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, The Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

## **II. Patient Safety Advisories**

When an untoward event occurs at the facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, Safety Watch newsletters are distributed. These alerts detail the circumstances that lead to a negative outcome and the facility is charged with assessment and improvement of their own processes to prevent similar occurrences. In addition, Clinical Risk Alerts and Medication Safety Alerts are also formulated to apprise the facilities of a specific safety issue that needs to be assessed to prevent reoccurrence.

**Desert View Hospital** is required to address the Safety Watch newsletters, Clinical Risk Alerts and Medication Safety Alerts via their Patient Safety Committee and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

## **C. TERM Program**

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate

organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

**Element I. Administration of the Risk Management Program:** The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

**Element II. Risk Identification:** Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

**Element III. Risk Education:** Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

**Element IV. Patient Safety Initiative:** Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC). The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

**Element V. Patient Safety Priority: Root Cause Analysis (RCA):** The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

**Element VI. Environment of Care; Safety and Security Programs:** The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

**Element VII. Claims and Litigation Management:** The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

**Element VIII. Patient Safety Organization (PSO):** Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their

responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

#### **D. MIDAS**

The MIDAS/ AMES- CCD system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

#### **E. Risk Connect (STARS)**

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by **XXX Hospital's** RM to the Governing Board of all claims activities.

#### **F. Event Notification Site**

The Event Notification Site or ENS, is a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and

stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

### **G. Root Cause Analysis (RCA)**

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that The Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

#### **RCA Responsibilities**

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



#### H. Patient Safety Checklists

By [NRS 439.865](#), the Patient Safety Plan must include the Patient Safety Checklists and Patient Safety Policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Patient Safety Checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.



- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

(For your reference— a checklist example is shown in **Appendix A.**)

## **I. Patient Safety Policies**

The Patient Safety Policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

## **J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)**

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out

patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

## K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired Risk Directors/Managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each Risk Director/Manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories
- Clinical Risk Alerts
- Medication Safety Alerts

## IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2020

- Surgical and Procedural Safety:
  - **Wrong Site Surgery (WSS).**
    - **Goal:** A 50% reduction in WSS events for 2020. Ultimately the goal is zero (0).
      - Monitor through Midas event reporting. Report monthly.
  - **Retained Procedural items (RPIs)**

- **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2020. Ultimately the goal for RPIs is 0.
    - Monitor through Midas event reporting. Report monthly.
- **OBHRU:**
  - **Reduction/Elimination of serious harm by reducing the response time to adverse obstetrical bleeding initiative.**
    - **Goal:** As evidenced by:
      - Education Module X: All new hire staff and providers to complete Hemorrhage module within 1st 3 months of employment. All current staff and providers who care for perinatal patients to complete Hemorrhage module every 2 years (even years).
      - Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results of Power Insights Hemorrhage report/dashboard.
      - All patients will receive POST BIRTH warning signs education for inpatient stay and discharge as evidenced by Power Insights report on education completion.
      - POST BIRTH collaborative benchmarking and assessment data from AWHONN/Premier collaborative.
    - Monitor through Powers Insights QBL compliance report/Midas/ENS/Claims data, GNOSIS results, and facility education reports. Report monthly.
- **CLABSI/CAUTI Initiative**
  - **Goal:** CLABSI and CAUTI will both be reduced to less than the National CMS mean Standardized Infection Ratio (SIR: CLABSI 0.783; CAUTI 0.857) in 2020.
  - Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly.
- **Safe Medication Use**
  - Opioid Analgesic Event Reduction Initiative
    - **Goal:** Decrease the number of preventable OIRD events by 10%.
    - Monitor through MIDAS reports, Cerner, ICD-10 Codes, and other intervention data. Report monthly.
- **Reduce Falls and Falls with Injury**

- **Goal:** 10 % overall reduction in the number of falls in the facility by end of 2020.
  - Review of the progressive mobility (PM) documentation in the facility.
  - Correlation of PM documentation and fall incidents.
  - Review of the documentation of PM in the ICU with LOS and length of intubation.
  - Review of documentation of mobility and progression of mobility.
  - Monitor through MIDAS event reporting. Report quarterly.
- **Culture of Safety**
    - **Goal:** 100% of 2020 Patient Safety Plan Priorities will be implemented within the facility.
    - Monitor through MIDAS event reporting with monthly reporting to PSC.

**Desert View Hospital:**

- **Goal:** Slip/Fall: Found on Floor for 2019 resulted in 299 events. 5% reduction per 2020 quarter is to be achieved.
- **Goal:** Against Medical Advice departures from the emergency department in 2019 equaled 429. The Emergency department Director/Staff will reduce patients leaving against medical advice reducing AMA's by 10% for each quarter of 2020.
- **Goal:** Left before triage and left without being seen departures from the emergency department in 2019 equaled 78. The Emergency department Director/Staff will reduce left before triage and left without being seen departures from the Emergency Department by 10% for each quarter of 2020.
- **Goal:** Violence within Desert View Hospital equaled 51 related event. 100% of the Emergency department staff are to receive Handle with Care Certification by July 2020 to reduce violence by a 5 % reduction from 2019 to 2020.
- **Goal:** Pyxis Optimization – Automatic Dispensing Cabinet there were 12 facility override events and 62 incorrect narcotic counts in 2019, and 71 Narcan usage events. Override events, incorrect narcotic events will be reduced by 10% for 2020. 100 % Emergency Department Registered Nursing staff will complete bar code medication administration training by April 2020.
- **Goal:** 100% of the emergency department registered nursing staff will adhere to bar code medication administration with a 90% or better compliance on a monthly basis.
- **Goal:** 2019 - High alert medication error reduction related to warfarin and insulin resulted in 5 events and 26 events respectively. A 10% reduction goal with warfarin and insulin medication administration errors is to be achieved in 2020.

## **V. Monitoring and Accountability**

### **A. Evaluation of TERM Program**

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

### **B. Patient Safety Committee**

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed and detailed feedback is provided to coach the committee on their form and function.

### **C. Dashboards**

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure.

## **VI. Evaluation/Review:**

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of "Near Miss" events
- The framework advances a "Just Culture" approach to patient safety
- Accountability is promoted when acts of "human error", "at risk", or "reckless behavior" are identified and corrected resulting in a reduction of potential/actual adverse outcomes.
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action
- Review of annualized and prior year's probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line

- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

**VII. Confidentiality**

All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities. The PSC annually reviews the effectiveness of the Safety Plan to ensure goals and objectives are appropriately focused on improving patient safety.

**VIII. Approval of Patient Safety Plan**

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the Governing Board of the facility for approval. After a facility’s patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.  
 The Patient Safety Plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current Patient Safety Plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

***Appendix A: Checklist Example: Injuries from Falls and Immobility***

Process Change	In Place	Not Done	Will Adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				

<b>Implement patient-specific intervention to prevent falls and injury</b>				
<b>Communicate risk across the team; use handoff forms, visual cues, huddles</b>				
<b>Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)</b>				
<b>Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds</b>				
<b>Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives</b>				
<b>Incorporate multidisciplinary input for falls</b>				
<b>Prevention from PT, OT, MD, RN and Phar.D.</b>				
<b>Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient</b>				
<b>Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls</b>				

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

The mission of Desert Willow Treatment Center is to provide quality, individualized mental health services in a safe and culturally sensitive environment collaborating with caregivers, community and other providers to ensure that children and families of Nevada may achieve their full human potential.

## Desert Willow Treatment Center QUALITY AND PATIENT SAFETY PLAN

DATE: 2020  
VERSION: 4





This plan was created and revised by the Desert Willow Treatment Center Patient Safety (Care of Patient) committee/team with coordination with applicable Continuing Quality Improvement Teams. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

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Patient Safety Committee/Care of Patient  
Desert Willow Treatment Center  
6171 W. Charleston Blvd, Building 17  
Las Vegas, NV 89146  
702-486-8900

## Commitment to Patient Safety

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Desert Willow Treatment Center is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

### Mission Statement

The mission of Desert Willow Treatment Center is to provide quality, individualized mental health services in a safe and culturally sensitive environment collaborating with caregivers, community and other providers to ensure that children and families of Nevada may achieve their full human potential.

In support of our mission Desert Willow Treatment Center Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high-quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

## Scope and Purpose

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The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Desert Willow Treatment Center are required to fully support and participate in this plan and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Desert Willow Treatment Center has developed this Patient Safety plan.

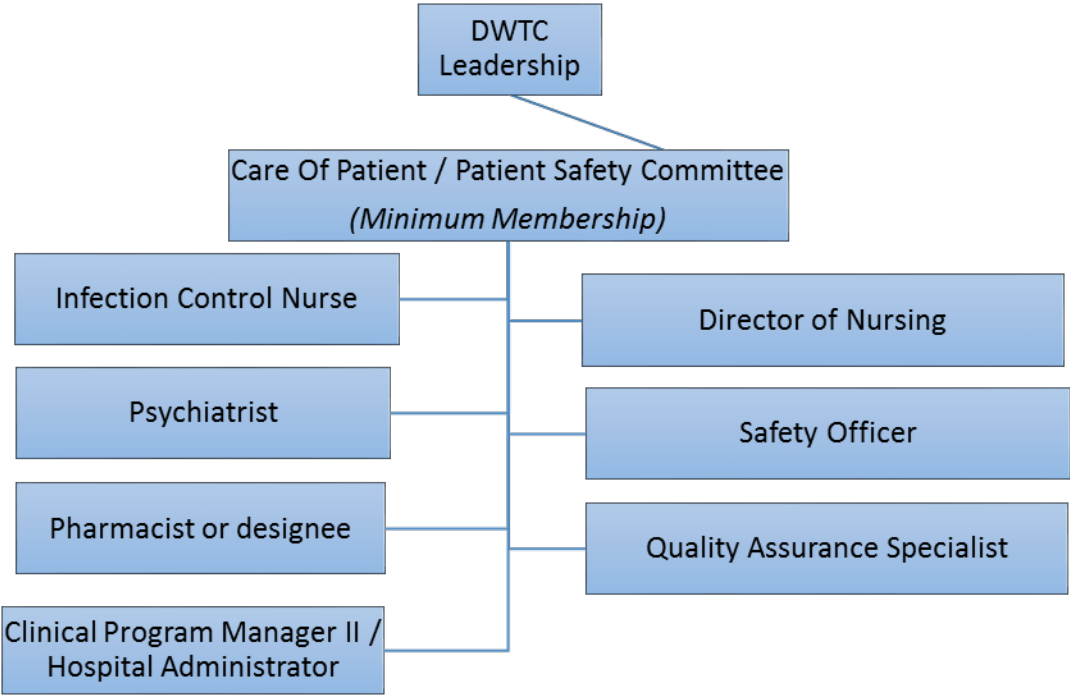
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

### Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully. Desert Willow Treatment Center’s Care of Patient Committee serves as the Patient Safety Committee.

The Patient Safety Committee Organization



### Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

### Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to Leadership to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

### Root Cause Analysis (RCA) Team

A Root Cause Analysis Team will be established following a Sentinel Event or any other event determined by Leadership as requiring a Root Cause Analysis.

#### Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.

- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

#### RCA Team Membership:

- DCFS Administrator will identify a Root Cause Analysis team leader who is not a current employee of Desert Willow Treatment Center
  - RCA team leader Responsibilities:
    - Organize and coordinate the RCA process.
    - Assemble and encourage a supportive and proactive team.
    - Assign investigative and implementation tasks to the team members.
    - Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Desert Willow Treatment Center Quality Assurance Specialist
- Desert Willow Treatment Center Safety Officer or designee
- Representation from the following disciplines within Desert Willow Treatment Center
  - Psychiatric Nurse
  - Mental Health Technician
  - Clinical Staff
  - Depending on the event other disciplines may be required
- DCFS Administrator, Deputy Administrator or Clinical Program Manager II may request additional representation from other agencies, disciplines or programs

#### Patient Safety Officer Responsibilities ([based on NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Serve as chairperson of the Environment of Care Committee

#### Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

- Communicate the progress of any infection control investigations, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process for infection control that incorporates the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities (Clinical Program Manager II / Hospital Administrator)

- Provide vision and leadership to Patient Safety and Quality Improvement process and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee/ Care of Patient Team will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Monitor and document the effectiveness of the patient safety policy.
  - Revise the patient safety policies and checklists as needed.
- A meeting agenda and minutes noting follow-up tasks will be kept.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

## Objectives and Goals of the Quality and Patient Safety Plan

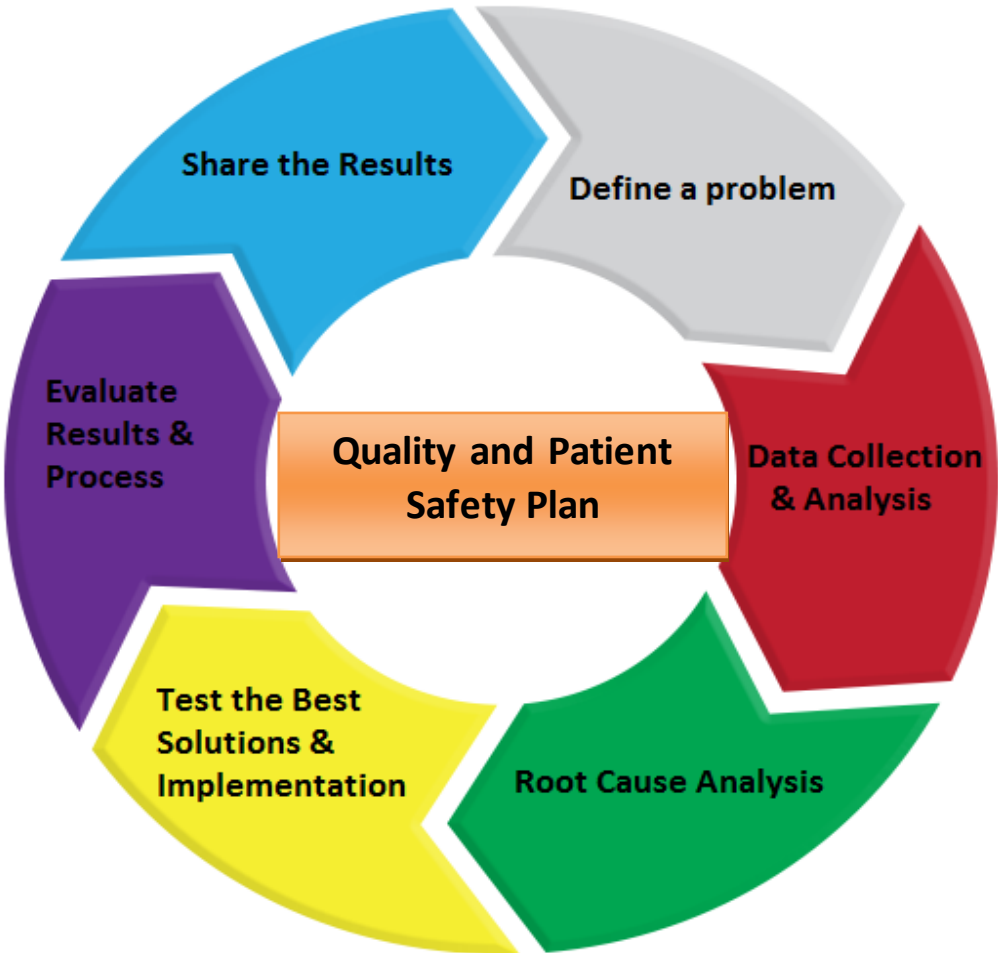
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- National Patient Safety Goals guide the service delivery process.
  - Identify Patients Correctly.
  - Use Medications Safely.
  - Prevent Infections.
  - Reduce the risk for suicide.
- Prevent Sentinel Events
  - Identify and Resolve Safety Risks for Patients including Environmental Factors
  - Root cause analysis will be done if sentinel event occurs
- Medication Management to include but not limited to:
  - Monitoring processes for high alert and look-alike/sound-alike medications
  - Reviewing the storage of medication, including expiration and temperatures
  - Reviewing appropriateness of drug order
  - Monitoring that patients have swallowed the oral medication, medication effects, adverse medication reactions and medication errors
  - Monitoring management of unused/expired medication
  - Monitoring Food/Drug/Drug interaction
  - Reviewing after hours dispensing and administration of medications
  - Providing medication education and handouts
  - Reconciling medication information including recording and passing along correct medication information to healthcare providers
- Nutrition Services
  - Provide balanced meals in compliance with the National School Lunch Program
  - Provide all patients with a working knowledge of the basic principles of nutrition and appropriate exercise while addressing potential dietary issues or medical concerns.
- PBIS
  - Continue to implement, evaluate effectiveness and consistency of PBIS program.
  - Update the program as necessary.
- Staff - Take acuity into consideration when staffing the units. Staff to be mindful of their own emotional needs and contact EAP for assistance when needed.
- Develop and maintain a plan for the prevention of and response to workplace violence.

## Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Desert Willow Treatment Center will use a RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.



### Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully



conducting root cause analysis.

**Root cause analysis and action plan framework table**, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

**5 Whys** technique will be used in Desert Willow Treatment Center to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram. 5 Why’s technique also can be used to drill down the problem and find the root causes.

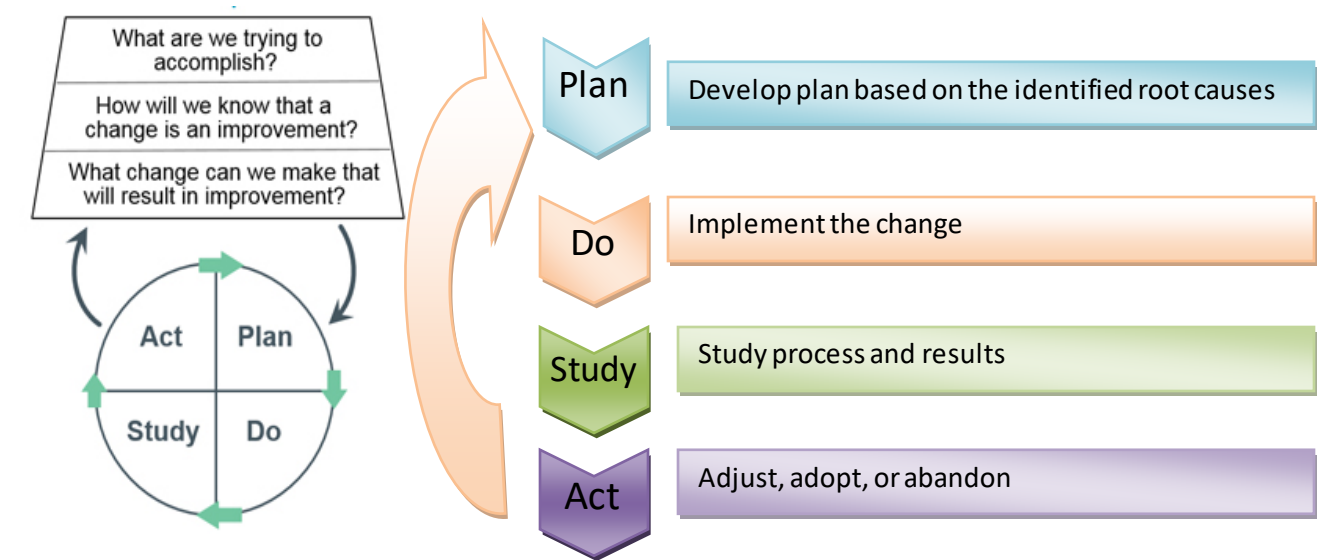
**Fishbone Diagram**

Once the problems are identified, a Fishbone Diagram (Appendix C) may be used for analyzing the problems. You may use the fishbone diagram individually to analyze the root causes or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics.

**Model for Improvement**

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
  - What is the objective of the test?
  - What are the steps for the test - who, what, when?
  - How will you measure the impact of the test?
  - What is your plan to collect the data needed?
  - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

## Data Collection and Reporting

Data should drive any quality and patient safety effort. Desert Willow Treatment Center is using DCFS Incident/ Accident Reports for tracking sentinel events, healthcare infection data, and Microsoft Excel and Access for internal data collection.

Data is submitted to the following external reporting entities:

- BHCQC: Bureau of Health Care Quality and Compliance
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- DPBH: Department of Public and Behavioral Health
- Southern Nevada Health District
- State of Nevada Child Death Review Team
- TJC: The Joint Commission
- LCB: Legislative Council Bureau

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report  2) Severity of infection report  3) RCA assessment	1) Severity of infection report  2) Review and evaluate the measure of improvement of patient safety  3) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update  2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

- Quarterly Incident Accident Report including Trigger Identification reported to the Performance Improvement Team and to Leadership
- Quarterly Consumer Complaint Report reported to Ethics Rights and Responsibilities Team and to Leadership
- Infection Control information reported to Patient Safety Committee/Care of Patient Team and to Leadership
- Root Cause Analysis for any Sentinel Event reviewed by all appropriate committees and to Leadership
- Corrective Action Plans reviewed by all appropriate committees and Leadership

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;

- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

The patient safety checklists are listed in Appendix D.

## Approval of Patient Safety Plan

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According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

## Reference

- Root Cause Analysis Toolkit – The Joint Commission  
[https://www.jointcommission.org/framework\\_for\\_conducting\\_a\\_root\\_cause\\_analysis\\_and\\_action\\_plan/](https://www.jointcommission.org/framework_for_conducting_a_root_cause_analysis_and_action_plan/)
- Department of Public and Behavioral Health Sentinel Event Reporting  
<https://dpbhrdc.nv.gov/redcap/>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2  
[https://www.jointcommission.org/sentinel\\_event.aspx](https://www.jointcommission.org/sentinel_event.aspx)

## Appendix A: Terms and Definitions

**Patient Safety:** The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”  
[http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick\\_110.pdf](http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf)

### **Sentinel event** ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

### **Facility-Associated Infection:** ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

### **Medical facility** ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);  
(Added to NRS by [2002 Special Session, 13](#))

**Near miss:** An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Mandatory reporting:** Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

**Risk:** Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

**Preventable event:** Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

## Appendix B: National Patient Safety Goals

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# 2020 Behavioral Health Care National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety.

The goals focus on problems in health care safety and how to solve them.

### Identify individuals served correctly

#### NPSG.01.01.01

Use at least two ways to identify individuals served. For example, use the individual's name *and* date of birth. This is done to make sure that each individual served gets the correct medicine and treatment.

### Use medicines safely

#### NPSG.03.06.01

Record and pass along correct information about an individual's medicines. Find out what medicines the individual served is taking. Compare those medicines to new medicines given to the individual served. Make sure the individual served knows which medicines to take when they are at home. Tell the individual served it is important to bring their up-to-date list of medicines every time they visit a doctor.

### Prevent infection

#### NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

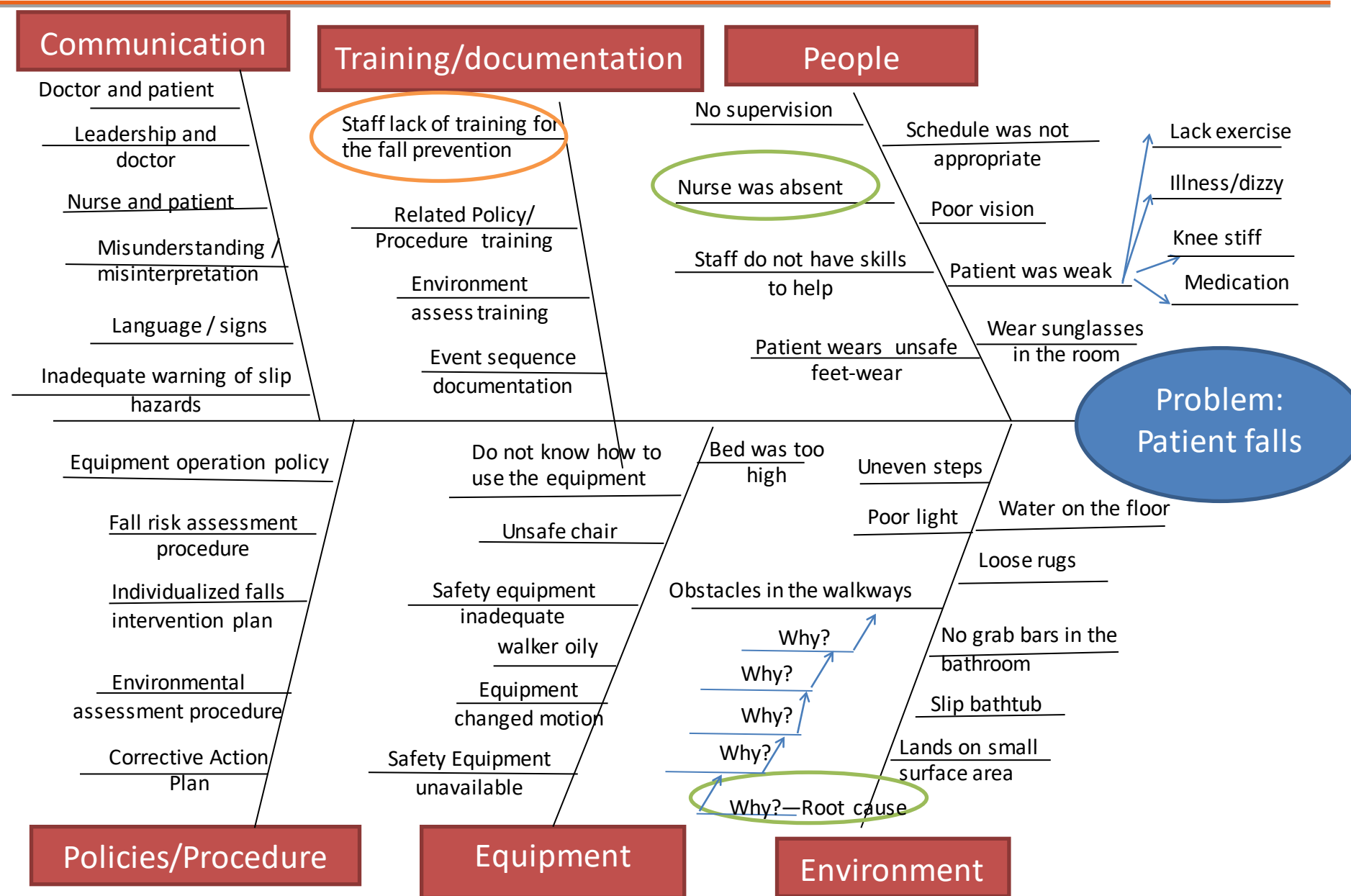
### Identify individuals served safety risks

#### NPSG.15.01.01

Reduce the risk for suicide.



## Appendix C: Fishbone Diagram



## Appendix D: Checklists

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### Universal Assessments A & B

<S:\DWTC\DWTC FORMS\DWTC 18A Universal Assessment Part A 12-19.doc>

<S:\DWTC\DWTC FORMS\DWTC 18B Universal Assessment Part B 12-19.doc>

Personal Safety Assessment <S:\DWTC\DWTC FORMS\DWTC 163 Personal Safety Assessment 12-17.docx>

### Pediatrician History & Physical Examination:

<S:\DWTC\DWTC FORMS\DWTC 19 Pediatrician History and Physical Examination 10-19.docx>

Aftercare Plan Located in Avatar (Electronic Health Record System)

ILSM Assessment Tool <S:\DWTC\DWTC FORMS\DWTC 192 Interim Life Safety Measure Assessment Tool 9-16.docx>

Monitoring Sheet <S:\DWTC\DWTC FORMS\DWTC 31 Patient Monitoring Sheet 6-17.xlsx>

Hygiene Monitoring Form <S:\DWTC\DWTC FORMS\DWTC 183 Hygiene Monitoring form 11-17.docx>

### Incident Accident Form

[S:\DWTC\DWTC FORMS\DWTC 72 Incident Accident Report 03-18 \(Print Two-Sided on Pink Paper\).pdf](S:\DWTC\DWTC FORMS\DWTC 72 Incident Accident Report 03-18 (Print Two-Sided on Pink Paper).pdf)

### Peer Review Forms

<S:\DWTC\DWTC FORMS\DWTC 141C CREDENTIALLED RN PEER REVIEW 09-16.doc>

<S:\DWTC\DWTC FORMS\DWTC 141 - CREDENTIALLED STAFF PEER REVIEW - PSYCHIATRIST 03-09.doc>

Medication Pass Audit <S:\DWTC\DWTC FORMS\DWTC 180 Medication Pass Audit 09-17.docx>

Unit Safety Contraband Checklist <S:\DWTC\DWTC FORMS\DWTC 182 Unit Safety Contraband Checklist 03-19.docx>

### Temperature Logs:

<S:\DWTC\DWTC FORMS\DWTC 120 A - Food Refrigerator-Freezer Temperature Log 05-18.doc>

<S:\DWTC\DWTC FORMS\DWTC 120 B - Medication Refrigerator Temperature Log 05-18.doc>

<S:\DWTC\DWTC FORMS\DWTC 120 C - Medication Room Temperature Log 6-17.doc>

Ebola Screening Tool <S:\DWTC\DWTC FORMS\DWTC 184 Ebola Screening Tool 04-16.docx>

Infection Surveillance Report <S:\DWTC\DWTC FORMS\DWTC 73 Infection Surveillance Report 02-17.docx>

### Environment of Care Monitors

<S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\10.0 - ENVIRONMENT OF CARE\10.50 - ENVIRONMENT OF CARE MONITORS 03-18.docx>

### Suicide Risk Assessment

[S:\DWTC\DWTC FORMS\DWTC 195A Suicide Risk Assessment & Safety Plan \(Admission\) 12-19.docx](S:\DWTC\DWTC FORMS\DWTC 195A Suicide Risk Assessment & Safety Plan (Admission) 12-19.docx)

[S:\DWTC\DWTC FORMS\DWTC 195B Suicide Risk Assessment \(Weekly\) 11-17.docx](S:\DWTC\DWTC FORMS\DWTC 195B Suicide Risk Assessment (Weekly) 11-17.docx)

[S:\DWTC\DWTC FORMS\DWTC 195C Suicide Risk Assessment & Safety Plan \(Discharge\) 11-17.docx](S:\DWTC\DWTC FORMS\DWTC 195C Suicide Risk Assessment & Safety Plan (Discharge) 11-17.docx)

Appendix E: Related Policies

DWTC Policy 1.19 Risk Management Plan  
[S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\01.0 - ORGANIZATION\1.19 - RISK MANAGEMENT PLAN.doc](#)

DWTC Policy 2.27 Contraband Items / Searches Personal and Room  
[S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\02.0 - ETHICS, RIGHTS, AND RESPONSIBILITIES\2.27 - CONTRABAND ITEMS - SEARCHES - PERSONAL & ROOM 6-16.docx](#)

DWTC Policy 2.29 Visitors & Guests  
[S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\02.0 - ETHICS, RIGHTS, AND RESPONSIBILITIES\2.29 - VISITORS & GUESTS 05-19.docx](#)

DWTC Policy 4.32 Root Cause Analysis  
[S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\04.0 - QUALITY ASSURANCE\4.32 - ROOT CAUSE ANALYSIS.doc](#)

DWTC Policy 4.33 Sentinel Events  
[S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\04.0 - QUALITY ASSURANCE\4.33 - SENTINEL EVENTS 6-15.doc](#)

DWTC Policies included in Chapter 10- Environment of Care  
[S:\DWTC\DWTC Policies & Procedures\DWTC POLICIES\10.0 - ENVIRONMENT OF CARE](#)

- |  |   |
|--|---|
| 10.01 Guidelines Hepatitis B Vaccine Program                       | 10.53 Security Management Plan                                    |
| 10.02 Influenza Program  | 10.54 Hazardous Materials and Waste Management Plan               |
| 10.03 Occupational Exposure to Bloodborne Pathogens                | 10.55 Fire Safety Plan (previously Life Safety Management Plan)   |
| 10.04 Infection Control of Ice Machine                             | 10.56 Emergency Management Plan                                   |
| 10.05 Health Safety Inspection                                     | 10.57 Utility Systems Disruption                                  |
| 10.06 Soiled Linen and Laundry Handling                            | 10.58 Medical Equipment Management Plan                           |
| 10.07 Interim Life Safety Measures                                 | 10.59 Emergency Codes / Public Address System                     |
| 10.08 Use of Disposable Gloves During Handling of Foods and Fluids | 10.60 Distribution of Linens                                      |
| 10.10 Surveillance, Prevention and Control of Infection Guidelines | 10.62 Non-Dairy Beverage Substitutions                            |
| 10.11 Personal Protective Equipment                                | 10.63 Diets and Food Requisitions                                 |
| 10.12 Housekeeping Procedures for Infection Control                | 10.64 Meals DWTC  |
| 10.13 Work Practice Controls                                       | 10.66 Nutritional Screening and Assessment                        |
| 10.14 Lice Policy  | 10.68 Dietetic Services Quality Improvement Plan                  |
| 10.15 Hand Washing   | 10.69 Diet Orders   |
| 10.16 Tuberculosis Screening for Patients                          | 10.70 Wellness Policy   |
| 10.17 Sanitation and Disinfection                                  | 10.73 Nutrition Care Monitoring                                   |
| 10.18 Isolation Techniques   | 10.74 Nutrition Care Manuals and Menu                             |
| 10.19 Nosocomial Detection and Reporting                           | 10.75 Nutrition Education   |
| 10.20 Occupational Illness   | 10.76 Meal Service  |
| 10.21 Infection Control and Surveillance Plan                      | 10.77 National School Lunch Program                               |
| 10.22 Standard Precautions   | 10.81 Incident-Accident Reporting                                 |
| 10.23 Transmission Based Precautions                               | 10.83 Incidents Involving State Vehicles                          |
| 10.25 Emergency Preparedness External Disaster                     | 10.85 Lockout-Tagout System                                       |
| 10.40 Maintenance Stand-By for After Hours                         | 10.86 Employee Lockers  |
| 10.41 Housekeeping/Maintenance                                     | 10.91 911 Emergency Protocol                                      |
| 10.44 Use of State Vehicles  | 10.92 Building Security   |
| 10.46 Non-Smoking/Smoking  | 10.93 Threats / Behavioral Emergencies in the Lobby / Intake Room |
| 10.47 Ordering of Supplies   | 10.94 Natural Gas Leak  |
| 10.50 Environment of Care Monitors                                 | 10.95 Potentially Dangerous Weapons                               |
| 10.51 Safety Management Plan                                       | 10.96 Bomb Threats  |
| 10.52 Utility Systems Management Plan                              | 10.99 Chemical Ingestion by Patient                               |
|  | 10.100 Hostage Situation  |
|  | 10.101 CCSD / DWTC Evacuation                                     |
|  | 10.102 Decorations  |

**Dignity Health – St. Rose Dominican  
Rose de Lima Campus**

**PATIENT SAFETY/RISK MANAGEMENT PLAN**

DATE: 01/2019



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This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program**  
**St. Rose Dominican – Rose de Lima Campus**  
102 East Lake Mead Parkway  
Henderson, NV 89052  
702.616.5552

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## Commitment to Patient Safety

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Dignity Health St. Rose Dominican Hospital – Rose de Lima Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

### Mission, Vision, and Values

In support of our mission, vision, and values, Dignity Health – St. Rose Dominican, Rose de Lima Campus' Patient Safety/Risk Management program promotes:

- Honest, open collaboration and partnership of hospital leadership, medical staff, patients and their families, the community and other healthcare providers to deliver compassionate, high-quality, affordable healthcare.
- Promote justice and respect for those we serve.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility and accountability for every healthcare related decision and action.
- A focus on excellence, teamwork and innovation through continuous learning, improvement in system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

## Scope and Purpose

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The Patient Safety/Risk Management Program at St. Rose Dominican is an organization-wide/campus specific strategy that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety/Risk Management Program at Rose de Lima Campus supports and encourages the active participation of each person in order to be an effective program. When processes, functions or services are designed or redesigned, information internal and external to the campus and/or organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or services.

The purpose of this plan is to establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program Plan designed to promote and improve patient safety at Dignity Health – St. Rose Dominican, Rose de Lima Campus, by working to prevent medical/healthcare adverse events and reducing risk to patients and visitors.

Undesirable facility specific and system patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns or trends vary significantly and undesirably from those expected including significant near misses;
- Performance varies significantly and undesirable from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
  - Hospital acquired infections
  - Medication events, to include delays in administration
  - Adverse drug events
  - Transfusion reactions
  - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

## Roles and Responsibilities

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Per [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

### The Patient Safety Committee Organization

#### Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;



- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Rose de Lima Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.

- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

#### Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- See Quality Department's Performance Improvement Plan

#### Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

The Manager of Risk Services has been designated the Patient Safety Officer for the Rose de Lima Campus and as such, has the administrative responsibility for the program specific responsibilities including:

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Day to day responsibility for the Patient Safety/Risk Management Program at Rose de Lima Campus.
- Maintenance of related data collected, trended and analyzed at each campus.
- Routine reporting to leadership and QCAC on campus specific trended data and actions taken to improve the quality and safety of patient care.
- Working with QCAC to achieve the goals of the Patient Safety/Risk Management Program.

#### Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.

- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

#### RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporates the Patient Safety and Quality Improvement elements.

#### RCA Facilitator Responsibilities

- Identify RCA participants and coordinate a time, date and location of RCA meeting.
- Inform RCA participants of the sentinel event process.
- Explain confidential nature of RCA.
- Explain Just Culture and its application.
- Review event using medical record and any other pertinent materials in preparation for the RCA.
- Provide RCA members access to relevant best practice/research documents/statutes and other literature to include hospital Policy and Procedure documents for reference.
- Conduct RCA in a manner consistent with Just Culture, using principles of human factors, systems theory, etc.

#### Executive or Governing Body Staff Responsibilities

Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.

### Leadership

The Dignity Health St. Rose Dominican Board and campus Senior Leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety/Risk Management Program. These responsibilities are campus specific and include the following:

- Foster an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.
- Establish a culture in which communication flows freely regardless of authority gradient.
- Ensure that a define, on-going, proactive program for identifying risks to patient safety and reducing medical/healthcare adverse events is fully implemented and includes responses to actual and potential events;
- Ensure that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Provide for mechanisms to measure, analyze and manage variation in the performance of defined processes that affect patient safety;
- Allocate adequate resources, including personnel, time, information systems data associated with reducing risk and improving patient safety, and
- Active participation in the California Hospital Patient Safety Organization (CHPSO).

### Physicians

Physicians are responsible, as participants in the Patient Safety/Risk Management Program for reporting events or near misses at each campus, and participating on focus teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (LIP) or comparable designee shall clearly explain these outcomes to the patient, and when appropriate, the family. (See Disclosure Policy)

### Patients/Families/Visitors

Patients, families and patient representatives via written communication are encouraged to be active participants in their care and as such are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to the patient's health;
- Reporting their patient and outcome of treatment of that pain
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner, and
- Asking questions when they do not understand what they have been told about the patient's care, infection control, safety precautions and programs or what they are expected to do etc.

Patients and families/patient representatives/visitors will be provided with educational materials explaining these expectations and their role in reducing risk exposure and improving patient safety at the time of admission and throughout the patient stay utilizing various delivery methods including pamphlets, television

and verbal communication. Some patients may also be included in the development process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

#### Hospital Departments and Staff

Rose de Lima staff are key to promoting, identifying, and implementing activities to reduce risk and improve patient safety. Some of the activities include:

- Active participation in the activities to improve patient safety and the quality of healthcare delivered;
- Adherence to Infection prevention measures, the Joint Commission National Patient Safety Goals and other patient safety initiatives;
- Participation in education activities and process implementations;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among caregivers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in information needs assessment, staff surveys, and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all events and process variances (harm or no harm) even if they do not reach the patient (near miss).

#### The Patient Safety Committee

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Rose de Lima Campus and includes multidisciplinary team members which have oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow up on patient safety related trends, analysis results, changes in processes, policies and other areas to make as a result of identified needs.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).

- Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

## Objectives and Goals of the Patient Safety/Risk Management Plan

Goal	Plan	Due Date
Risk Assessments	1. Patient Safety/Risk Management to perform monthly risk assessments and report to PSC. 2. Infection Prevention to report to PSC findings of Risk Assessments.	Monthly PSC
FMEA	PSC to ensure one FMEA is conducted by Risk Management in CY 2019.	December 2019
Checklists	PSC will receive all new and renewed checklists used that impact patient safety whether directly or indirectly.	Monthly and ongoing
National Patient Safety Goals	PSC will support the posting of NPSGs throughout the hospital for staff reference.	Department leaders
Root Cause Analysis	RCAs will be conducted by Risk and Quality Management as soon as possible/practical after an event per Dignity Health policy	Ongoing
Manager orientation	Quality Risk Services will review/update Manager orientation.	March 31, 2019
Grievance Management	Grievances will be reviewed by the Grievance Committee to ensure compliance with CMS CoPs.	Quarterly and ongoing.

Goal	Plan	Due Date
Staff and physician education	Patient Safety education will occur in various forms (e.g. Huddles, Department Meetings, Leadership Meetings, Posters) throughout the year.	Ongoing

## Components and Methods

### **Proactive Risk Assessment Activities**

The Patient Safety/Risk Management Department, in collaboration with the various facility committees including Infection Prevention, Quality Council and leadership will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk Assessment activities will include, but not be limited to the following:

- Patient Safety Risk Assessment evaluating known high risk processes/procedures that have associated risks,
- Review employee survey results to identify safety concerns,
- On-going risk assessments based on internal and external data, including sentinel event alerts,
- Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.
- Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of Rose de Lima campus,
- Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.
- Patient Satisfaction surveys will include a question determining how the patient/family thinks the individual facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.
- Infection Prevention Surveillance Program.
- Additional staff surveys may be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety, as well as the staff's willingness to report medical/healthcare events.

### **Event Reporting**

Rose de Lima actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration and evaluation activities. As provided under the CHPSO (42 Code of Federal Regulations (CFR) Part 3 Section 3.20) the event report is considered a Patient Safety Work Product and as such is privileged and shall not be (1) subject to subpoena; (2) subject to discovery; (3) subject to disclosure and (4) admitted into evidence-provided such information is not subject to disclosure in certain criminal proceedings as described in regulation. (See Event Reporting and Management Policy).

- A. When an unplanned event/process variance occurs, the patient care provider will do the following:
  - a. Perform the necessary healthcare interventions to support the patient's clinical condition.
  - b. Perform the necessary interventions to contain the risks to others.
  - c. Notify the patient's attending physician.
  - d. Preserve any information related to the event including physical evidence. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Report and in the patients' medical record.

- e. Notify immediate supervisor of the event.
  - f. Submit electronically an Event Report form or handwritten Event Report form to Risk Management/Patient Safety Services.
- B. Identification of potential unsafe condition that may affect patient safety:
- a. Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
  - b. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

#### **Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention**

- A. Patient safety related event reporting data within the scope of the Patient Safety Program and risk assessment results will be aggregated and presented routinely to various committees including but not limited to Medical Executive Committee (MEC), Medication Safety, Quality Council and Environment of Care for analysis and action. Based on analysis of this data and any actual or potential reviews, sentinel events and other internal and external data including TJC Sentinel Event Alerts, Dignity Health Shared Learnings, CHPSO trends, current literature, proactive action plan will be developed to include the following:
- a. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
  - b. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
  - c. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
  - d. Redesign of the process and /or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
  - e. Test and implement the redesign process;
  - f. Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and
  - g. Implementation of a strategy for maintaining the effectiveness of the process over time.
  - h. Events that do not require a Root Cause Analysis will have an incident review completed by Quality/Risk Services Department as soon as practicable of becoming aware of the event. The results will be forwarded to leadership for review.

#### **Response to Reported Adverse/Sentinel Events**

Reporting of events is an essential component of a Patient Safety/Risk Management program. Through its participation in the CHPSO; all related investigation of events will be securely conducted, collected and documented as Patient Safety Work Product (PSWP) to maintain confidentiality as defined in the Federal Regulation.

- A. Rose de Lima shall respond to all reported potential and actual adverse/sentinel events. (See Sentinel Event policy).
- B. Minimally, all adverse events will be analyzed utilizing a team of individuals including Risk Management/Patient Safety and Quality Departments, to conduct root cause analysis (RCA), incident review and/or a failure mode effects analysis (FMEA), implementation in action plan to reduce further risk to patients and establish measures of effectiveness.
- a. The following events always elicit an intense analysis:
    - i. Confirmed transfusion reactions



- ii. Significant adverse drug reactions
  - iii. Significant medication events and hazardous conditions
  - iv. Manor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
  - v. Significant adverse events associated with anesthesia use.
  - vi. Hospital acquired infections
  - vii. All events meeting the definition of Sentinel Events in the State of Nevada.
- b. A root cause analysis is performed when a sentinel or State reportable event occurs.
- c. An incident review is performed when a near miss or other event with significant areas for improvement are identified.
- C. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
  - a. A “JUST CULTURE” approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
  - b. Involved staff should be involved in the RCA process.
  - c. The Department Manager will provide ongoing support to the staff member(s) as needed.
  - d. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

## **Education**

- A. Staff Education
  - a. General orientation and other education and training programs as needed will emphasize specific job related aspects of patient safety and risk reduction strategies.
  - b. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
    - i. An overview of the Patient Safety Program
    - ii. Overview of TJC National Patient Safety Goals
    - iii. Staff’s role and responsibilities in the Patient Safety/Risk Management Program
    - iv. Event reporting criteria and process
    - v. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care
    - vi. Examples of specific job related aspects of patient safety.
  - c. Staff participating at a higher level of the Patient Safety/Risk Management Program will receive appropriate training necessary to understand and complete their assigned responsibilities.
- B. Physician Education
  - a. An overview of the Patient Safety/Risk Management Program will be provided to physicians at time of initial appointment and annually thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
  - b. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Rose de Lima Campus will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, developed by the Institute of Health Care Improvement, that we will use to test the changes.



## Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

**Root cause analysis and action plan framework table**, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

**5 Whys** technique will be used in Rose de Lima Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

### Fishbone Diagram

Once the problems are identified, a Fishbone Diagram will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Whys technique also can be used to drill down the problem and find the root causes.

### Model for Improvement

Please refer to the Dignity Health – St. Rose Dominican Performance Improvement Plan.

### Data Collection and Reporting

Data should drive any quality and patient safety effort. Rose de Lima is using IVOS<sub>for</sub> tracking the sentinel events, healthcare infection data, and Midas for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

### Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measure to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

## Assessment of the Quality and Patient Safety Plan

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Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

## Patient Safety Checklists and Patient Safety Policies

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By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

[http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>

## Approval of Patient Safety Plan

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According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

### **Patient Safety Program Reporting and Review**

All patient safety work product (PSWP) submitted through the CHPSO will be collected in the Patient Safety Evaluation System (PSES) for collection, management and analysis of information pursuant to the Patient Safety and Quality Improvement Act of 2005 ( 42 U.S.C. 299 et seq.).

- A. Patient safety/Risk Management related data and information reports will be provided routinely to various committees as previously identified including but not limited to medical staff, Quality Council and QCAC.

- B. A summary report of data, other internal and external information, as well as all actions taken by various committees and/or specific patient safety related teams will be submitted to the QCAC and the MEC.
- C. Annually, the Patient Safety/Risk Management Plan will be evaluated for effectiveness and the program updated to reflect the results of risk assessments related to patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.
  - a. The review will be approved by QCAC.
  - b. Will be submitted to the Community Board for final review and approval.

## References

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- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools  
[http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/plan\\_do\\_study\\_act.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html)
- CQI 101 An Introduction to Continuous Quality Improvement:  
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2  
[https://www.jointcommission.org/sentinel\\_event.aspx](https://www.jointcommission.org/sentinel_event.aspx)
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>
- Checklists to Improve Patient Safety [http://www.hpo.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpo.org/Reports-HPOE/CkLists_PatientSafety.pdf)
- Minutes of the Meeting of the Quality and Patient Safety Committee  
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

### Reviewed/Approved:

Patient Safety Committee, January 2019

Quality Care Advisory Committee of the Board, January 2019

Community Board, January 2019

**Dignity Health – St. Rose Dominican  
San Martin Campus**

**PATIENT SAFETY/RISK MANAGEMENT PLAN**

DATE: 01/2019



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This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program**  
**St. Rose Dominican – San Martin Campus**  
8280 West Warm Springs Road  
Las Vegas, NV 89113  
702.616.5552



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## Commitment to Patient Safety

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Dignity Health St. Rose Dominican Hospital – San Martin Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe 2018 for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

### Mission, Vision, and Values

In support of our mission, vision, and values, Dignity Health – St. Rose Dominican, San Martin Campus' Patient Safety/Risk Management program promotes:

- Honest, open collaboration and partnership of hospital leadership, medical staff, patients and their families, the community and other healthcare providers to deliver compassionate, high-quality, affordable healthcare.
- Promote justice and respect for those we serve.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility and accountability for every healthcare related decision and action.
- A focus on excellence, teamwork and innovation through continuous learning, improvement in system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

## Scope and Purpose

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The Patient Safety/Risk Management Program at St. Rose Dominican is an organization-wide/campus specific strategy that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety/Risk Management Program at San Martin Campus supports and encourages the active participation of each person in order to be an effective program. When processes, functions or services are designed or redesigned, information internal and external to the campus and/or organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or services.

The purpose of this plan is to establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program Plan designed to promote and improve patient safety at Dignity Health – St. Rose Dominican, San Martin Campus, by working to prevent medical/healthcare adverse events and reducing risk to patients and visitors.

Undesirable facility specific and system patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns or trends vary significantly and undesirably from those expected including significant near misses;
- Performance varies significantly and undesirable from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
  - Hospital acquired infections
  - Medication events, to include delays in administration
  - Adverse drug events
  - Transfusion reactions
  - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

## Roles and Responsibilities

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Per [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

### The Patient Safety Committee Organization

#### Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;

- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the San Martin Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.

- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

#### Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- See Quality Department's Performance Improvement Plan

#### Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

The Manager of Risk Services has been designated the Patient Safety Officer for the San Martin Campus and as such, has the administrative responsibility for the program specific responsibilities including:

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Day to day responsibility for the Patient Safety/Risk Management Program at San Martin Campus.
- Maintenance of related data collected, trended and analyzed at each campus.
- Routine reporting to leadership and QCAC on campus specific trended data and actions taken to improve the quality and safety of patient care.
- Working with QCAC to achieve the goals of the Patient Safety/Risk Management Program.

#### Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.

- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

#### RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporates the Patient Safety and Quality Improvement elements.

#### RCA Facilitator Responsibilities

- Identify RCA participants and coordinate a time, date and location of RCA meeting.
- Inform RCA participants of the sentinel event process.
- Explain confidential nature of RCA.
- Explain Just Culture and its application.
- Review event using medical record and any other pertinent materials in preparation for the RCA.
- Provide RCA members access to relevant best practice/research documents/statutes and other literature to include hospital Policy and Procedure documents for reference.
- Conduct RCA in a manner consistent with Just Culture, using principles of human factors, systems theory, etc.

#### Executive or Governing Body Staff Responsibilities

Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.

#### Leadership

The Dignity Health St. Rose Dominican Board and campus Senior Leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety/Risk Management Program. These responsibilities are campus specific and include the following:

- Foster an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.
- Establish a culture in which communication flows freely regardless of authority gradient.
- Ensure that a define, on-going, proactive program for identifying risks to patient safety and reducing medical/healthcare adverse events is fully implemented and includes responses to actual and potential events;
- Ensure that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Provide for mechanisms to measure, analyze and manage variation in the performance of defined processes that affect patient safety;
- Allocate adequate resources, including personnel, time, information systems data associated with reducing risk and improving patient safety, and
- Active participation in the California Hospital Patient Safety Organization (CHPSO).

### Physicians

Physicians are responsible, as participants in the Patient Safety/Risk Management Program for reporting events or near misses at each campus, and participating on focus teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (LIP) or comparable designee shall clearly explain these outcomes to the patient, and when appropriate, the family. (See Disclosure Policy)

### Patients/Families/Visitors

Patients, families and patient representatives via written communication are encouraged to be active participants in their care and as such are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to the patient's health;
- Reporting their patient and outcome of treatment of that pain
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner, and
- Asking questions when they do not understand what they have been told about the patient's care, infection control, safety precautions and programs or what they are expected to do etc.

Patients and families/patient representatives/visitors will be provided with educational materials explaining these expectations and their role in reducing risk exposure and improving patient safety at the time of admission and throughout the patient stay utilizing various delivery methods including pamphlets, television and verbal communication. Some patients may also be included in the development process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

### Hospital Departments and Staff

San Martin staff are key to promoting, identifying, and implementing activities to reduce risk and improve patient safety. Some of the activities include:

- Active participation in the activities to improve patient safety and the quality of healthcare delivered;
- Adherence to Infection prevention measures, the Joint Commission National Patient Safety Goals and other patient safety initiatives;
- Participation in education activities and process implementations;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among caregivers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in information needs assessment, staff surveys, and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all events and process variances (harm or no harm) even if they do not reach the patient (near miss).

### The Patient Safety Committee

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the San Martin Campus and includes multidisciplinary team members which have oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow up on patient safety related trends, analysis results, changes in processes, policies and other areas to make as a result of identified needs.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.



- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

## Objectives and Goals of the Patient Safety/Risk Management Plan

Goal	Plan	Due Date
Risk Assessments	1. Patient Safety/Risk Management to perform monthly risk assessments and report to PSC. 2. Infection Prevention to report to PSC findings of Risk Assessments.	Monthly PSC
FMEA	PSC to ensure one FMEA is conducted by Risk Management in CY 2019.	December 2019
Checklists	PSC will receive all new and renewed checklists used that impact patient safety whether directly or indirectly.	Monthly and ongoing
National Patient Safety Goals	PSC will support the posting of NPSGs throughout the hospital for staff reference.	Department leaders
Root Cause Analysis	RCAs will be conducted by Risk and Quality Management as soon as possible/practical after an event per Dignity Health policy	Ongoing
Manager orientation	Quality Risk Services will review/update Manager orientation.	March 31, 2019
Grievance Management	Grievances will be reviewed by the Grievance Committee to ensure compliance with CMS CoPs.	Quarterly and ongoing.
Staff and physician education	Patient Safety education will occur in various forms (e.g. Huddles, Department Meetings, Leadership Meetings, Posters) throughout the year.	Ongoing

## Components and Methods

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### **Proactive Risk Assessment Activities**

The Patient Safety/Risk Management Department, in collaboration with the various facility committees including Infection Prevention, Quality Council and leadership will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk Assessment activities will include, but not be limited to the following:

- Patient Safety Risk Assessment evaluating known high risk processes/procedures that have associated risks,
- Review employee survey results to identify safety concerns,
- On-going risk assessments based on internal and external data, including sentinel event alerts,
- Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.
- Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of San Martin campus,
- Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.
- Patient Satisfaction surveys will include a question determining how the patient/family thinks the individual facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.
- Infection Prevention Surveillance Program.
- Additional staff surveys may be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety, as well as the staff's willingness to report medical/healthcare events.

### **Event Reporting**

San Martin actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration and evaluation activities. As provided under the CHPSO (42 Code of Federal Regulations (CFR) Part 3 Section 3.20) the event report is considered a Patient Safety Work Product and as such is privileged and shall not be (1) subject to subpoena; (2) subject to discovery; (3) subject to disclosure and (4) admitted into evidence-provided such information is not subject to disclosure in certain criminal proceedings as described in regulation. (See Event Reporting and Management Policy).

- A. When an unplanned event/process variance occurs, the patient care provider will do the following:
  - a. Perform the necessary healthcare interventions to support the patient's clinical condition.
  - b. Perform the necessary interventions to contain the risks to others.
  - c. Notify the patient's attending physician.
  - d. Preserve any information related to the event including physical evidence. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Report and in the patients' medical record.
  - e. Notify immediate supervisor of the event.
  - f. Submit electronically an Event Report form or handwritten Event Report form to Risk Management/Patient Safety Services.

- B. Identification of potential unsafe condition that may affect patient safety:
  - a. Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
  - b. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

#### **Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention**

- A. Patient safety related event reporting data within the scope of the Patient Safety Program and risk assessment results will be aggregated and presented routinely to various committees including but not limited to Medical Executive Committee (MEC), Medication Safety, Quality Council and Environment of Care for analysis and action. Based on analysis of this data and any actual or potential reviews, sentinel events and other internal and external data including TJC Sentinel Event Alerts, Dignity Health Shared Learnings, CHPSO trends, current literature, proactive action plan will be developed to include the following:
  - a. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
  - b. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
  - c. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
  - d. Redesign of the process and /or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
  - e. Test and implement the redesign process;
  - f. Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and
  - g. Implementation of a strategy for maintaining the effectiveness of the process over time.
  - h. Events that do not require a Root Cause Analysis will have an incident review completed by Quality/Risk Services Department as soon as practicable of becoming aware of the event. The results will be forwarded to leadership for review.

#### **Response to Reported Adverse/Sentinel Events**

Reporting of events is an essential component of a Patient Safety/Risk Management program. Through its participation in the CHPSO; all related investigation of events will be securely conducted, collected and documented as Patient Safety Work Product (PSWP) to maintain confidentiality as defined in the Federal Regulation.

- A. San Martin shall respond to all reported potential and actual adverse/sentinel events. (See Sentinel Event policy).
- B. Minimally, all adverse events will be analyzed utilizing a team of individuals including Risk Management/Patient Safety and Quality Departments, to conduct root cause analysis (RCA), incident review and/or a failure mode effects analysis (FMEA), implementation in action plan to reduce further risk to patients and establish measures of effectiveness.
  - a. The following events always elicit an intense analysis:
    - i. Confirmed transfusion reactions
    - ii. Significant adverse drug reactions
    - iii. Significant medication events and hazardous conditions

- iv. Manor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
- v. Significant adverse events associated with anesthesia use.
- vi. Hospital acquired infections
- vii. All events meeting the definition of Sentinel Events in the State of Nevada.
- b. A root cause analysis is performed when a sentinel or State reportable event occurs.
- c. An incident review is performed when a near miss or other event with significant areas for improvement are identified.
- C. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
  - a. A “JUST CULTURE” approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
  - b. Involved staff should be involved in the RCA process.
  - c. The Department Manager will provide ongoing support to the staff member(s) as needed.
  - d. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

### **Education**

- A. Staff Education
  - a. General orientation and other education and training programs as needed will emphasize specific job related aspects of patient safety and risk reduction strategies.
  - b. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
    - i. An overview of the Patient Safety Program
    - ii. Overview of TJC National Patient Safety Goals
    - iii. Staff’s role and responsibilities in the Patient Safety/Risk Management Program
    - iv. Event reporting criteria and process
    - v. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care
    - vi. Examples of specific job related aspects of patient safety.
  - c. Staff participating at a higher level of the Patient Safety/Risk Management Program will receive appropriate training necessary to understand and complete their assigned responsibilities.
- B. Physician Education
  - a. An overview of the Patient Safety/Risk Management Program will be provided to physicians at time of initial appointment and annually thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
  - b. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

San Martin Campus will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, developed by the Institute of Health Care Improvement, that we will use to test the changes.



## Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

**Root cause analysis and action plan framework table**, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

**5 Whys** technique will be used in San Martin Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

### Fishbone Diagram

Once the problems are identified, a Fishbone Diagram will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Whys technique also can be used to drill down the problem and find the root causes.

### Model for Improvement

Please refer to the Dignity Health – St. Rose Dominican Performance Improvement Plan.

### Data Collection and Reporting

Data should drive any quality and patient safety effort. San Martin is using IVOS for tracking the sentinel events, healthcare infection data, and Midas for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

### Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

## Assessment of the Quality and Patient Safety Plan

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Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

## Patient Safety Checklists and Patient Safety Policies

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By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

[http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>

## Approval of Patient Safety Plan

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According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

### **Patient Safety Program Reporting and Review**

All patient safety work product (PSWP) submitted through the CHPSO will be collected in the Patient Safety Evaluation System (PSES) for collection, management and analysis of information pursuant to the Patient Safety and Quality Improvement Act of 2005 ( 42 U.S.C. 299 et seq.).

- A. Patient safety/Risk Management related data and information reports will be provided routinely to various committees as previously identified including but not limited to medical staff, Quality Council and QCAC.
- B. A summary report of data, other internal and external information, as well as all actions taken by various committees and/or specific patient safety related teams will be submitted to the QCAC and the MEC.



- C. Annually, the Patient Safety/Risk Management Plan will be evaluated for effectiveness and the program updated to reflect the results of risk assessments related to patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.
- a. The review will be approved by QCAC.
  - b. Will be submitted to the Community Board for final review and approval.

## References

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- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools [http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/plan\\_do\\_study\\_act.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html)
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 [https://www.jointcommission.org/sentinel\\_event.aspx](https://www.jointcommission.org/sentinel_event.aspx)
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>
- Checklists to Improve Patient Safety [http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

### Reviewed/Approved:

Patient Safety Committee, January 2019

Quality Care Advisory Committee of the Board, January 2019

Community Board, January 2019

**Dignity Health – St. Rose Dominican  
Siena Campus**

**PATIENT SAFETY/RISK MANAGEMENT PLAN**

DATE: 01/2019



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This plan was created and revised by the Dignity Health – St. Rose Dominican Patient Safety Officer with review and input from the Patient Safety Committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program  
St. Rose Dominican – Siena Campus**

3001 St. Rose Parkway  
Henderson, NV 89052  
702.616.5552

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## Commitment to Patient Safety

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Dignity Health St. Rose Dominican Hospital – Siena Campus is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

### Mission, Vision, and Values

In support of our mission, vision, and values, Dignity Health – St. Rose Dominican, Siena Campus' Patient Safety/Risk Management program promotes:

- Honest, open collaboration and partnership of hospital leadership, medical staff, patients and their families, the community and other healthcare providers to deliver compassionate, high-quality, affordable healthcare.
- Promote justice and respect for those we serve.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility and accountability for every healthcare related decision and action.
- A focus on excellence, teamwork and innovation through continuous learning, improvement in system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

## Scope and Purpose

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The Patient Safety/Risk Management Program at St. Rose Dominican is an organization-wide/campus specific strategy that includes not only facility staff and medical staff, but is inclusive of patients, family and visitors. The Patient Safety/Risk Management Program at Siena Campus supports and encourages the active participation of each person in order to be an effective program. When processes, functions or services are designed or redesigned, information internal and external to the campus and/or organization regarding potential risks to patient safety will be considered and where appropriate, utilized to minimize the risk to patients affected by the new or redesigned process, function or services.

The purpose of this plan is to establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program Plan designed to promote and improve patient safety at Dignity Health – St. Rose Dominican, Siena Campus, by working to prevent medical/healthcare adverse events and reducing risk to patients and visitors.

Undesirable facility specific and system patterns or trends in performance and sentinel events will be intensively analyzed to determine where best to focus changes for improvement. Intensive analysis will be initiated when:

- Levels of performance, patterns or trends vary significantly and undesirably from those expected including significant near misses;
- Performance varies significantly and undesirable from that of other campuses/organizations;
- Performance varies significantly and undesirably from recognized standards; and/or
- A reportable event has occurred at that campus.

Minimally, data from the following areas will be gathered at each facility and presented at that facility for analysis with action plans developed reflective of the findings:

- Initial and on-going proactive risk assessments utilizing internal and external resources;
- Campus aggregate event reports reflective of all medical/healthcare events, with and without adverse outcomes, including but not limited to:
  - Hospital acquired infections
  - Medication events, to include delays in administration
  - Adverse drug events
  - Transfusion reactions
  - Patient falls
- Actual and near misses
- Hazardous conditions
- Restraint issues
- Medical record legibility issues
- Patient/family/staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety;
- Identified data trends and analysis reports from sister facilities, Dignity Health Shared Learnings, etc.
- Others as defined by various campus committees, Leadership and/or Quality Council and Advisory Committee of the Board (QCAC).

## Roles and Responsibilities

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Per [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

### The Patient Safety Committee Organization

#### Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;

- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below.

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Siena Campus and includes multidisciplinary team members which has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following are responsibilities assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators.
- Evaluate other sources of patient safety data utilizing internal and external resources including but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow-up on patient safety related trends, analysis results, changes in processes, and policies.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

- (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
- (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

#### Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- See Quality Department's Performance Improvement Plan

#### Patient Safety Officer Responsibilities ([based on NRS 439.870](#))

The Manager of Risk Services has been designated the Patient Safety Officer for the Siena Campus and as such, has the administrative responsibility for the program specific responsibilities including:

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Day to day responsibility for the Patient Safety/Risk Management Program at Siena Campus.
- Maintenance of related data collected, trended and analyzed at each campus.
- Routine reporting to leadership and QCAC on campus specific trended data and actions taken to improve the quality and safety of patient care.
- Working with QCAC to achieve the goals of the Patient Safety/Risk Management Program.

#### Infection Control Officer Responsibilities ([based on NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.



- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

#### RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporates the Patient Safety and Quality Improvement elements.

#### RCA Facilitator Responsibilities

- Identify RCA participants and coordinate a time, date and location of RCA meeting.
- Inform RCA participants of the sentinel event process.
- Explain confidential nature of RCA.
- Explain Just Culture and its application.
- Review event using medical record and any other pertinent materials in preparation for the RCA.
- Provide RCA members access to relevant best practice/research documents/statutes and other literature to include hospital Policy and Procedure documents for reference.
- Conduct RCA in a manner consistent with Just Culture, using principles of human factors, systems theory, etc.

#### Executive or Governing Body Staff Responsibilities

Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.

- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans.

#### Leadership

The Dignity Health St. Rose Dominican Board and campus Senior Leadership has overall responsibility for the implementation of an integrated, organization-wide Patient Safety/Risk Management Program. These responsibilities are campus specific and include the following:

- Foster an environment in which patients, their families and organization staff and leaders can identify and manage actual and potential risks to patient safety through personal example and the provision of resources to establish proactive mechanisms to reduce risk.

- Establish a culture in which communication flows freely regardless of authority gradient.
- Ensure that a define, on-going, proactive program for identifying risks to patient safety and reducing medical/healthcare adverse events is fully implemented and includes responses to actual and potential events;
- Ensure that patient safety issues are given a high priority and addressed when processes, functions or services are designed or redesigned;
- Provide for mechanisms to measure, analyze and manage variation in the performance of defined processes that affect patient safety;
- Allocate adequate resources, including personnel, time, information systems data associated with reducing risk and improving patient safety, and
- Active participation in the California Hospital Patient Safety Organization (CHPSO).

### Physicians

Physicians are responsible, as participants in the Patient Safety/Risk Management Program for reporting events or near misses at each campus, and participating on focus teams to reduce identified patient safety risks. Whenever patient care outcomes differ significantly from the anticipated outcomes, the primary care provider and/or responsible licensed independent practitioner (LIP) or comparable designee shall clearly explain these outcomes to the patient, and when appropriate, the family. (See Disclosure Policy)

### Patients/Families/Visitors

Patients, families and patient representatives via written communication are encouraged to be active participants in their care and as such are responsible for:

- Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to the patient's health;
- Reporting their patient and outcome of treatment of that pain
- Reporting perceived risks in their care and unexpected changes in the patient's condition to the responsible practitioner, and
- Asking questions when they do not understand what they have been told about the patient's care, infection control, safety precautions and programs or what they are expected to do etc.

Patients and families/patient representatives/visitors will be provided with educational materials explaining these expectations and their role in reducing risk exposure and improving patient safety at the time of admission and throughout the patient stay utilizing various delivery methods including pamphlets, television and verbal communication. Some patients may also be included in the development process to obtain their opinions, needs, perceptions of risks to patients and their suggestions for improving patient care.

### Hospital Departments and Staff

Siena staff are key to promoting, identifying, and implementing activities to reduce risk and improve patient safety. Some of the activities include:

- Active participation in the activities to improve patient safety and the quality of healthcare delivered;

- Adherence to Infection prevention measures, the Joint Commission National Patient Safety Goals and other patient safety initiatives;
- Participation in education activities and process implementations;
- As appropriate, the provision of accurate, timely and complete verbal and written communication among caregivers, including test results relevant to the management of the patient's condition, and to all others involved in the utilization of data; and
- Participation in information needs assessment, staff surveys, and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all events and process variances (harm or no harm) even if they do not reach the patient (near miss).

#### The Patient Safety Committee

The Patient Safety Committee convenes monthly in accordance with NRS 439.875. In collaboration with the Patient Safety Officer, the committee represents the Siena Campus and includes multidisciplinary team members which have oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety/Risk Management Program within the facility/organization.
- Establish and evaluate data to identify patient safety performance indicators;
- Evaluate other sources of patient safety data utilizing internal and external resources including, but not limited to adopted patient safety checklists, risk assessments, sentinel event report/alert information and event reporting information from a variety of available resources including the event reporting system, APIC, CHPSO, etc.;
- Selection of a high-risk patient safety process for proactive risk assessment and improvement annually;
- Collaborates with each facility's Quality Council to identify, address and conduct follow up on patient safety related trends, analysis results, changes in processes, policies and other areas to make as a result of identified needs.
- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.
- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

## Objectives and Goals of the Patient Safety/Risk Management Plan

Goal	Plan	Due Date
Risk Assessments	1. Patient Safety/Risk Management to perform monthly risk assessments and report to PSC. 2. Infection Prevention to report to PSC findings of Risk Assessments.	Monthly PSC
FMEA	PSC to ensure one FMEA is conducted by Risk Management in CY 2019.	December 2019
Checklists	PSC will receive all new and renewed checklists used that impact patient safety whether directly or indirectly.	Monthly and ongoing
National Patient Safety Goals	PSC will support the posting of NPSGs throughout the hospital for staff reference.	Department leaders
Root Cause Analysis	RCAs will be conducted by Risk and Quality Management as soon as possible/practical after an event per Dignity Health policy	Ongoing
Manager orientation	Quality Risk Services will review/update Manager orientation.	March 31, 2019
Grievance Management	Grievances will be reviewed by the Grievance Committee to ensure compliance with CMS CoPs.	Quarterly and ongoing.
Staff and physician education	Patient Safety education will occur in various forms (e.g. Huddles, Department Meetings, Leadership Meetings, Posters) throughout the year.	Ongoing

## Components and Methods

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### **Proactive Risk Assessment Activities**

The Patient Safety/Risk Management Department, in collaboration with the various facility committees including Infection Prevention, Quality Council and leadership will conduct proactive risk assessments to identify hazards/risks that may affect patient safety. Risk Assessment activities will include, but not be limited to the following:

- Patient Safety Risk Assessment evaluating known high risk processes/procedures that have associated risks,
- Review employee survey results to identify safety concerns,
- On-going risk assessments based on internal and external data, including sentinel event alerts,
- Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.
- Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of Siena campus,
- Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.
- Patient Satisfaction surveys will include a question determining how the patient/family thinks the individual facility can improve patient safety. Results from this question shall be analyzed and responded to in a manner that supports risk reduction.
- Infection Prevention Surveillance Program.
- Additional staff surveys may be conducted to assess for staff opinions, needs, perceptions of risks to patients and suggestions for improving patient safety, as well as the staff's willingness to report medical/healthcare events.

### **Event Reporting**

Siena actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration and evaluation activities. As provided under the CHPSO (42 Code of Federal Regulations (CFR) Part 3 Section 3.20) the event report is considered a Patient Safety Work Product and as such is privileged and shall not be (1) subject to subpoena; (2) subject to discovery; (3) subject to disclosure and (4) admitted into evidence-provided such information is not subject to disclosure in certain criminal proceedings as described in regulation. (See Event Reporting and Management Policy).

- A. When an unplanned event/process variance occurs, the patient care provider will do the following:
  - a. Perform the necessary healthcare interventions to support the patient's clinical condition.
  - b. Perform the necessary interventions to contain the risks to others.
  - c. Notify the patient's attending physician.
  - d. Preserve any information related to the event including physical evidence. Preservation of the information includes the documentation of facts regarding the event or complication of event on the Event Report and in the patients' medical record.
  - e. Notify immediate supervisor of the event.
  - f. Submit electronically an Event Report form or handwritten Event Report form to Risk Management/Patient Safety Services.
- B. Identification of potential unsafe condition that may affect patient safety:

- a. Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
- b. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

#### **Event Monitoring/Risk Assessment Analysis, Action Planning and Intervention**

- A. Patient safety related event reporting data within the scope of the Patient Safety Program and risk assessment results will be aggregated and presented routinely to various committees including but not limited to Medical Executive Committee (MEC), Medication Safety, Quality Council and Environment of Care for analysis and action. Based on analysis of this data and any actual or potential reviews, sentinel events and other internal and external data including TJC Sentinel Event Alerts, Dignity Health Shared Learnings, CHPSO trends, current literature, proactive action plan will be developed to include the following:
  - a. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
  - b. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
  - c. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
  - d. Redesign of the process and /or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
  - e. Test and implement the redesign process;
  - f. Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and
  - g. Implementation of a strategy for maintaining the effectiveness of the process over time.
  - h. Events that do not require a Root Cause Analysis will have an incident review completed by Quality/Risk Services Department as soon as practicable of becoming aware of the event. The results will be forwarded to leadership for review.

#### **Response to Reported Adverse/Sentinel Events**

Reporting of events is an essential component of a Patient Safety/Risk Management program. Through its participation in the CHPSO; all related investigation of events will be securely conducted, collected and documented as Patient Safety Work Product (PSWP) to maintain confidentiality as defined in the Federal Regulation.

- A. Siena shall respond to all reported potential and actual adverse/sentinel events. (See Sentinel Event policy).
- B. Minimally, all adverse events will be analyzed utilizing a team of individuals including Risk Management/Patient Safety and Quality Departments, to conduct root cause analysis (RCA), incident review and/or a failure mode effects analysis (FMEA), implementation in action plan to reduce further risk to patients and establish measures of effectiveness.
  - a. The following events always elicit an intense analysis:
    - i. Confirmed transfusion reactions
    - ii. Significant adverse drug reactions
    - iii. Significant medication events and hazardous conditions

- iv. Minor discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
  - v. Significant adverse events associated with anesthesia use.
  - vi. Hospital acquired infections
  - vii. All events meeting the definition of Sentinel Events in the State of Nevada.
- b. A root cause analysis is performed when a sentinel or State reportable event occurs.
- c. An incident review is performed when a near miss or other event with significant areas for improvement are identified.
- C. Staff involved in an adverse/sentinel event shall be treated with respect and dignity.
  - a. A “JUST CULTURE” approach shall be taken in order to facilitate changes in systems and processes to prevent further risk to patient safety, as well as promote future reporting by other staff.
  - b. Involved staff should be involved in the RCA process.
  - c. The Department Manager will provide ongoing support to the staff member(s) as needed.
  - d. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

## **Education**

- A. Staff Education
  - a. General orientation and other education and training programs as needed will emphasize specific job related aspects of patient safety and risk reduction strategies.
  - b. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
    - i. An overview of the Patient Safety Program
    - ii. Overview of TJC National Patient Safety Goals
    - iii. Staff’s role and responsibilities in the Patient Safety/Risk Management Program
    - iv. Event reporting criteria and process
    - v. Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care
    - vi. Examples of specific job related aspects of patient safety.
  - c. Staff participating at a higher level of the Patient Safety/Risk Management Program will receive appropriate training necessary to understand and complete their assigned responsibilities.
- B. Physician Education
  - a. An overview of the Patient Safety/Risk Management Program will be provided to physicians at time of initial appointment and annually thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism.
  - b. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Siena Campus will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, developed by the Institute of Health Care Improvement, that we will use to test the changes.



## Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

**Root cause analysis and action plan framework table**, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

**5 Whys** technique will be used in Siena Campus to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.



### Fishbone Diagram

Once the problems are identified, a Fishbone Diagram will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Whys technique also can be used to drill down the problem and find the root causes.

### Model for Improvement

Please refer to the Dignity Health – St. Rose Dominican Performance Improvement Plan.

### Data Collection and Reporting

Data should drive any quality and patient safety effort. Siena is using IVOS<sub>2</sub> for tracking the sentinel events, healthcare infection data, and Midas for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

### Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measure to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

## Assessment of the Quality and Patient Safety Plan

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Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

## Patient Safety Checklists and Patient Safety Policies

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By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

[http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)

The following link provides you some patient safety policies for your reference

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>

## Approval of Patient Safety Plan

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According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

### **Patient Safety Program Reporting and Review**

All patient safety work product (PSWP) submitted through the CHPSO will be collected in the Patient Safety Evaluation System (PSES) for collection, management and analysis of information pursuant to the Patient Safety and Quality Improvement Act of 2005 ( 42 U.S.C. 299 et seq.).

- A. Patient safety/Risk Management related data and information reports will be provided routinely to various committees as previously identified including but not limited to medical staff, Quality Council and QCAC.
- B. A summary report of data, other internal and external information, as well as all actions taken by various committees and/or specific patient safety related teams will be submitted to the QCAC and the MEC.

- C. Annually, the Patient Safety/Risk Management Plan will be evaluated for effectiveness and the program updated to reflect the results of risk assessments related to patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.
- a. The review will be approved by QCAC.
  - b. Will be submitted to the Community Board for final review and approval.

## References

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- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools [http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/plan\\_do\\_study\\_act.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html)
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 [https://www.jointcommission.org/sentinel\\_event.aspx](https://www.jointcommission.org/sentinel_event.aspx)
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies-and-guidelines>
- Checklists to Improve Patient Safety [http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)
- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

### Reviewed/Approved:

Patient Safety Committee, January 2019

Quality Care Advisory Committee of the Board, January 2019

Community Board, January 2019

DINI-TOWNSEND HOSPITAL

PROTOCOL

SUBJECT: PATIENT SAFETY PROGRAM

NUMBER: DT-PI-02

Page 1 of 7

ORIGINAL DATE: 2/18/10

REVIEW/REVISE DATE: 7/18/13, 11/22/16, 10/23/18, 1/28/20

APPROVAL: \_\_\_\_\_ Agency Manager

APPROVAL: \_\_\_\_\_ Local Governing Body

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I. PURPOSE

To enhance patient care delivery and prevent adverse outcomes of care by employing a systematic, coordinated, and continuous approach to the improvement of patient safety.

II. PROTOCOL

The Patient Safety Program is supported by leadership's promotion of a blame-free culture of safety that:

1. Facilitates reporting and follow-up on errors, adverse events, risks, and safety concerns.
2. Initiates, monitors, and takes action to reduce errors and risks of errors.
3. Reports findings and actions taken.
4. Educates employees to ensure their knowledge of and participation in the program.

### III. DEFINITIONS

1. Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.
2. Near Miss: Any process variation which did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome.
3. Health Care-Associated Infection (HAI): A localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility.
4. Incident: An event that is not consistent with routine patient care or hospital procedure which either did or could have resulted in injury, loss to a patient, employee, or visitor; or which may give rise to a claim against the hospital, an employee, or a member of the medical staff.
5. Error: An unintended act, either omission or commission, or an act that does not achieve its outcome such as medication errors and adverse drug events or reactions.
6. Just Culture: A culture that does not hold individual practitioners accountable for system failings, and recognizes competent professionals make mistakes, but has zero tolerance for reckless behavior.

### IV. REFERENCES

1. Nevada Revised Statutes (NRS) 439.865 to 439.890 Patient safety plan; patient safety committee; patient safety officer; patient safety checklists and policies.
2. NRS 439.802 Facility-acquired infections defined.

3. The Joint Commission Comprehensive Accreditation Manual for Hospitals, National Patient Safety Goals and Patient Safety Systems Chapters.
4. Dini-Townsend Hospital Protocol DT-EC-08 Environmental Safety and Security Management.
5. Dini-Townsend Hospital Protocol DT-IC-06 Hand Hygiene.
6. Dini-Townsend Hospital Protocol DT-IC-07 Standard Precautions.
7. Dini-Townsend Hospital Protocol DT-PI-03 Sentinel Events.
8. Division of Public and Behavioral Health (DPBH) electronic Discharge Interdisciplinary Continuity of Care Form (ICOC).

## V. OBJECTIVES

1. To collect and analyze data to evaluate processes for opportunities to proactively reduce risk and correct potential system failures.
2. To respond appropriately to any error, adverse event, or sentinel event.
3. To incorporate recognition of patient safety as an integral job responsibility.
4. To encourage organizational learning about adverse or potential adverse events.
5. To improve hospital safety culture by encouraging reporting, measuring safety culture on a regular basis, and involving employees in addressing needed change.

## VI. SCOPE

- A. Areas of focus include sentinel events, near misses, errors, and other incidents related to:
  1. Health care-associated infections.
  2. Medication errors.

3. Adverse drug events.
  4. Drug recalls.
  5. Other product recalls.
  6. Patient falls.
  7. Other patient incidents.
  8. Blood and body fluid exposures.
  9. Communicable disease exposures.
  10. Influenza vaccination program.
- B. Data from external sources, including but not limited to:
1. The Joint Commission.
  2. Centers for Medicare and Medicaid Services.
  3. Centers for Disease Control and Prevention.
  4. Institute for Safe Medication Practices.
  5. National Quality Forum.

## VII. PATIENT SAFETY COMMITTEE

- A. The Patient Safety Committee provides an interdisciplinary forum for the analysis of risk to patient safety and for the dissemination of information on identified risk for the purpose of improving patient care.
- B. Membership includes:
1. The Patient Safety Officer – Accreditation and QAPI Manager.
  2. The Agency Manager.
  3. The Director of Nursing.
  4. The Director of Pharmacy Services.
  5. The Infection Control Officer.
  6. The Environmental Safety Officer - Facilities Supervisor.
  7. The Medical Director or other member of the medical staff.



- C. The Patient Safety Committee has adopted patient safety checklists and policies, including, but not limited to:
1. Checklists related to treatment or specific types of treatment.
  2. Checklists ensuring that the patient's environment is sanitary.
  3. An electronic discharge form which includes instructions concerning aftercare and medications (ICOC).
  4. Other checklists that may ensure patient safety.
  5. A procedure for appropriately identifying a patient with two personal identifiers.
  6. A hand hygiene protocol regarding standard precautions.
- D. The Patient Safety Committee meets monthly and will:
1. Review reports and evaluate the actions of the Patient Safety Officer on sentinel events and other incidents.
  2. Review, discuss, and evaluate Root Cause Analyses (RCAs) and corrective actions associated with serious incidents.
  3. Review emerging research and best practice standards related to patient safety.
  4. Promote a hospital-wide coordinated effort to comply with The Joint Commission's National Patient Safety Goals and Patient Safety Systems chapters.
  5. Review and disseminate information it receives to the appropriate committees or individuals, including, learned lessons from incident reports, to increase awareness and promote continuous improvement and a just culture.
  6. Make recommendations concerning identified risks and evaluate the implementation of corrective action plans.
  7. Review the patient safety checklists and policies at least annually and revise as necessary.

8. Ensure compliance with the patient safety checklists and policies, which may include:
  - a. Hand hygiene monitoring.
  - b. Audits of sanitation logs.
  - c. Review of health records.
  - d. Performance improvement indicator reports.
  - e. Communication to employees.

E. The Patient Safety Officer will:

1. Serve on the Patient Safety Committee.
2. Manage the agency incident reporting system.
3. Report all sentinel events to the Nevada Sentinel Event Registry, and to The Joint Commission where applicable.
4. Conduct investigations, RCAs, and monitor corrective action plans for completion and effectiveness.
5. Take action in collaboration with the Patient Safety Committee and leadership to ensure the safety of patients.
6. Report quarterly, to the Local Governing Body, the number and severity of sentinel events, and any recommendations to reduce the number and severity of sentinel events.
7. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report will include a summary of any new checklist development, or, revision and use of the checklists and policies.
8. On or before March 1<sup>st</sup> of each year, submit a report to the Nevada Sentinel Event Registry, summarizing the previous calendar year's sentinel events and Patient Safety Committee activities.

## VII. SAFETY IMPROVEMENT ACTIVITIES

- A. Incident reporting trending and analysis.
- B. Medication error reporting and trending.
- C. Other potential errors/prescription interventions tracked by pharmacy.
- D. Infection surveillance and prevention.
- E. Monitoring hand hygiene.
- F. Tracking assault, seclusion and restraint data.
- G. Appropriate implementation of input from patients, families, and employees.
- H. Environmental safety rounds.
- I. Environmental safety monitoring by Environment of Care Committee.
- J. Reactive analysis (RCA) of incidents.
- K. Proactive risk assessment (failure mode effect analysis).
- L. Antibiotic Stewardship Program.
- M. Culture of Safety Employee Survey.

## VIII. EMPLOYEE EDUCATION AND TRAINING

- A. Employees are educated on safety issues, policies, protocols, and procedures during new employee orientation, including department specific orientation.
- B. Annual employee education includes safety education.
- C. Employees are updated on all new agency protocols or protocol revisions.
- D. Employees participate on teams for proactive or reactive analysis and are, thus encouraged to participate in the improvement of safety.
- E. Employees are provided feedback on the results of the Culture of Safety Survey.
- F. Employees participate with leaders in addressing Culture of Safety Survey data.

|                                                                               |                                                                                                                                                |                                              |
|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| <b>Facility Name:</b><br><br><b>Durango<br/>Outpatient<br/>Surgery Center</b> | <b>Policy And Procedure Guideline Name:</b><br><br><b>Patient Safety + Quality Improvement<br/>Program</b><br><br><b>(Environment Of Care)</b> | <b>Policy Number:</b><br><br><b>SAFE 104</b> |
|                                                                               | <b>Subject Category:</b><br><br><b>SAFETY</b>                                                                                                  | <b>Effective Date:</b><br><b>10/01/2016</b>  |
|                                                                               |                                                                                                                                                | <b>Revised Date:</b><br><b>1/15/20</b>       |
|                                                                               |                                                                                                                                                | <b>Page 1 Of 6</b>                           |

**Policy:** Durango Surgery Center shall provide guidelines and implement proactive practices, which provide a safe environment of care in relation to property, equipment, patients, personnel and the public. The facility and each OR must be designed and maintained so that all types of surgery can be performed in a manner that protects the lives and assures the physical safety of all individuals.

**Purpose:** This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, environment, challenges and revise the program to better serve the patients and their families. To this end, Durango Surgery Center has developed this Patient Safety + Quality Improvement Plan.

Our plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes.

Mission Vision and Value: As we seek to improve the quality of our patients' lives, to serve our communities, to provide an exceptional environment for our employees and physicians. We are guided by:

- Quality: is at the core of everything we do and every decision we make.
- Integrity: We manage our business with integrity and the highest ethical standards. Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Service: We have a culture of service that values teamwork and focuses on the needs of others. We operate with transparency by measuring our results.
- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.

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- 1 -

- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.

## **Procedure Guidelines:**

### **Responsibility:**

This committee will be comprised of at least: Safety Officer, Infection Control Officer, Pharmacy, Executive Member, and Medical Director

1. Durango Surgery Center leadership takes action to minimize identified safety risks in the physical environment. Employees are responsible for:
  - A. Intervention when, safety conditions pose a threat to life or health, or threaten damage to equipment or buildings.
  - B. The continuing maintenance of the facility property, eliminating hazards upon discovery.
  - C. Reporting equipment or maintenance problems and incidents of property damage to the Administrator/ Clinical Director upon discovery.
  - D. Reporting injuries and illness to the Administrator/Clinical Director.
  - E. Obtaining the information necessary to perform tasks in a manner that prevents injury to themselves, patients and others.
2. The Administrator/Clinical Director, and Safety Officer, as agents of the Quality Assurance Committee are responsible for:
  - A. Patient safety + Environment of Care development, implementation and monitoring.
  - B. Report of Safety Surveillance and activities to the Quality Assurance Committee/PI committee.
  - C. Every 12 months the organization evaluates the Environment of Care Plan for objectives, scope, performance and effectiveness.

## **Maintenance and Supervision:**

1. Comply with the NFPA 101®, Life Safety Code® (LSC) for maintaining and supervising the facility grounds, buildings and equipment.
2. Maintain equipment and utilities following a preventative maintenance schedule.
3. Maintain sufficient light in the parking and entrance areas to reduce the potential for falls and security concerns.
4. Maintain signs and emergency systems to meet the needs of the visual and hearing impaired.

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5. Maintain smoke free environment.
6. Provide facility cleaning, maintenance, and inspection, following a schedule for daily, weekly, monthly, semi-annual and annual activities.
7. Construction and Renovation (Interim Life Safety Plan):
  - A. Meet the existing ambulatory health care occupancy health code requirements for construction or renovation.
  - B. Train staff in alternative safety processes including the use of new specialized equipment and space.
  - C. Train staff to compensate for changes in Life Safety Plan.
  - D. Provide increased facility safety monitoring with construction and renovation included reference to the NFPA 101®, Life Safety Code® (LSC).
  - E. Inspect and monitor components of Life Safety Plan weekly or more frequently if indicated.

**Risk Assessment:**

1. Provide risk assessment and hazard surveillance to evaluate the impact of the center building, grounds, equipment, occupants, and internal physical systems on patient, employee and public safety.
  - A. Assign a Safety Officer to maintain risk and hazard surveillance.
  - B. Record Hazard surveillance.
  - C. Report environmental hazard and safety surveillance to the Quality Assurance Committee. Provide follow-up to staff concerning safety issue recommendations.
2. Report and document patient, personnel or visitor injury, and occupational illness. Document incidents on a Variance Report, Occurrence Report, or Incident Report.
  - A. Investigate and evaluate each report for opportunities to improve performance using: **Root Cause Analysis Framework:**

Root Cause Analysis (RCA) Team Responsibilities

Root Cause interviews, analysis, investigation, and corrective action plan implementations. Participates in the RCA meetings and discussions. Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders. Include injuries and occupational illness in the report to the Quality Assurance Committee.

- B. Patient Safety QA Committee Responsibilities (based on NRS 439.875 and NRS 439.877)
  - i. Monitor and document the effectiveness of the patient identification policy.

- ii. Clinical Director will supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835. Each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4)(b).
- iii. Receive reports from the patient safety officer pursuant to NRS 439.870.
- iv. Based on NRS 439.865, the patient safety plan must also include an infection control program see: infection control policies.
- v. Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- vi. Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- vii. At least once each calendar month (or quarter), report to the executive or governing body of the facility by way of Administrator or Clinical Director regarding:
  - 1. The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - 2. The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; with recommendations to reduce such events.

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

| Monthly                                                                                          | Quarterly                                                                                                                                                                                                                            | Annually                                                                                           |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| 1) Sentinel event monthly report<br><br>2) Severity of infection report<br><br>3) RCA assessment | 1) Sentinel event quarterly report<br><br>2) Severity of infection report<br><br>3) Review and evaluate the measure of improvement of patient safety<br><br>4) Review and evaluate the measurement to prevent and control infections | 1) Quality and Patient Safety Plan update<br><br>2) Checklists and Policies reviewing and revising |

**Product Safety Recalls:**

- 1. Address a product safety recall upon notification.

- A.** Inventory and remove recalled product from possible use.
- B.** Notify affected medical staff and evaluate a substitute product.
- C.** Inventory patients who may have received a recalled medical device from implant logs or records.
- D.** Consult with the Medical Director and/or Quality Assurance Committee to evaluate the situation and determine an appropriate method for patient notification if an implanted medical device has been recalled. The medical director, as an agent of the QA/PI committee reports the incident to the Medical Executive Committee.

**Safety Education:**

- 1.** Provide Safety Education and Training at orientation and at least annually thereafter. Address general safety processes; area specific safety and job related hazards.
- 2.** Provide Safety Guidelines in the General Orientation including:
  - A.** Review of Safety Policies and Guidelines.
  - B.** Body Mechanics.
  - C.** Hazardous Materials Communication.
  - D.** SDS/ Hazardous Waste.
  - E.** Safety Risk / Responsibilities.
  - F.** Equipment Safety/Operations Manuals.
  - G.** Emergency Preparedness.
  - H.** Utility Systems and Electrical Safety.
  - I.** Infection Control/Exposure OSHA.
  - J.** Reporting of Sentinel Events.
  - K.** Variance, accidents/injuries, Security and Safety concerns.
  - L.** Fire and Life Safety.
  - M.** Safety Concerns.
  - N.** Security



**O. OSHA.**

- 3.** Include specific safety standards related to safe practices and the safe use, inspection, cleaning and maintenance of specialized equipment in the Department /Job Specific orientation.
- 4.** Provide updates when new equipment is introduced.
- 5.** Review General Safety Guidelines annually.

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

**Reference:**

Center for Medicare and Medicaid Services (April, 2015). Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery.

The Joint Commission. (2017) Accreditation Standards and Requirements for Ambulatory Surgery Centers

## Encompass Health Rehabilitation Hospital of Desert Canyon

|                          |                            |                                |
|--------------------------|----------------------------|--------------------------------|
| Policy#: 180             | Title: Safety Plan         | Category: Plans                |
| Policy Status: Published | Effective Date: 06/14/2019 | Last Reviewed Date: 06/14/2019 |

### PROCEDURE

#### **PURPOSE:**

The purpose of the Safety Program is to improve patient safety and reduce risk to patients, staff and visitors. Recognizing that effective error/risk reduction requires an integrated and coordinated approach, we have developed a hospital-wide safety program. The program supports the creation of an environment in which, our staff and leaders can identify and manage actual and potential risks to safety and elevate expectations and outcomes through our Core Values.

#### **DEFINITIONS:**

**Patient Safety Events:** A *patient safety event* is an event, incident, or condition that could have resulted or did result in harm to a patient. A patient safety event can be, but is not necessarily, the result of a defective system or process design, a system breakdown, equipment failure, or human error. Patient safety events also include adverse events, no-harm events, near misses and unsafe conditions which are defined for the purposes of this policy as follows:

An **adverse event** is a patient safety event that resulted in harm to a patient. These events must be assessed to determine if they fit the criteria for a Sentinel Event.

A **no-harm event** is a patient safety event that reaches the patient but does not cause harm.

A **near miss/good catch** is an event that occurred but did not reach the patient because of active recovery efforts by caregivers or by chance alone.

An **unsafe condition** is a circumstance that increases the probability of an adverse event

A **Sentinel Event** is defined as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and is considered "sentinel" because it signals a need for immediate investigation and response.

#### **RESPONSIBILITY:**

1. The ultimate responsibility for the implementation and operation of this Plan is vested in the hospital CEO.
2. The CEO has delegated day-to-day monitoring and function of this Plan to the Director of Quality/Risk (DQR).
3. The Safety Committee and Quality Council will provide interdisciplinary input and oversight related to patient, visitor and staff safety.

#### **PROCEDURES:**

##### **This Plan requires:**

1. Staff will be oriented to the Safety Plan on hire, as well as risks specific to their role, and through ongoing in-service and other education and training programs, as needed.
2. Staff will be oriented to their roles in preventing and reporting adverse occurrences as related to their specific job responsibilities and as a part of the hospital-wide efforts to improve patient safety. *Policy 600, Electronic Event Reporting* describes the process for reporting of every occurrence which meets the following definition: any happening not consistent with the routine care or operation of the facility, or the desired routine care of the patient and/or operation of the facility, which places our patients and visitors at increased risk for harm.
3. All members of the leadership team are responsible for interacting with staff in a manner that promotes a just culture and encourages open reporting of safety risks.
4. The leadership team members may request the assistance of internal behavioral management staff or external resources if a staff member(s) needs support in coping with an adverse event.
5. Hospital leadership will identify barriers to effective communication among caregivers relative to patient care, redesign of processes to eliminate barriers to communication and monitor communication for effectiveness. Specific attention will be directed to the processes for ensuring accurate, timely, and complete verbal and written communication among care givers and all others involved in utilization of data, and
6. All patients are entitled to information about all aspects of their health care, including information about clinically relevant unanticipated outcomes of care.

Patients and, when appropriate, their families are informed about the outcomes of care including unanticipated outcomes (i.e. medical error, sentinel events, state reportable events). Responsibility for disclosing unanticipated outcomes typically rests with the physician or designee who has overall responsibility for the patient's care. However, in some situations, other healthcare professionals may be deemed more appropriate to be responsible for disclosing the outcome. A hospital representative, preferably the DQR, Chief Nursing Officer or the Chief Executive Officer should be present for the initial conversation and any follow-up discussions that may occur with the patient and/or patient's representative.

7. The DQR or designee will respond promptly to notification of significant safety events to a patient/visitor.
  - A. The Nursing Supervisor or Department Manager will contact the DQR and/or Administrator/Administrator-On-Call to report events, as appropriate and assure that a report describing the facts of the event is entered into RL Solutions
  - B. Action(s) will be taken to protect the patient/visitor as necessary..
  - C. The Governing Body/Quality Committee has delegated the task of investigation of adverse events The DQR will initiate an investigation. Under authority of these Committees, factual information will be obtained by the DQR and preserved for subsequent analysis by the appropriate individuals. Such information is confidential for quality assurance purposes.
8. The hospital will implement the *Performance Improvement Plan (Policy 160)* in order to have in place a coordinated, comprehensive and ongoing method of assessing the effectiveness of all care and risk reduction efforts.
9. The facility will also perform intense analysis consistent with the *Sentinel Event Policy (Policy 692)*.. The DQR/designee is responsible for ensuring compliance with proper reporting internally and externally.
10. On admission patients/family members are oriented to the importance of reporting perceived risks and concerns about the patient's care according to the *Patient and Customer Complaint and Grievance Policy (Policy 008)*.
11. Hospital leadership will review Patient Satisfaction Survey responses related to safety and develop a corrective action plan to patient/family complaints or suggestions for improving safety as appropriate and in accordance with Policy 008.
14. The Governing Board has appointed the DQR as the Patient Safety Officer. The Patient Safety Officer/Director's role includes:

- Participating in hazard surveillance, event reporting, reviewing, and the development of patient safety policies and procedures.
- Analyzing and seeking resolution of patient safety issues and works with the appropriate staff to implement recommendations and to monitor patient safety improvement activities.
- Report on findings, recommendations, actions taken, and results of measurements through the hospital quality structure.

15. Hospital leadership will measure and assess the effectiveness of their contributions to improving patient safety. To accomplish these goals, leaders will.

- A. Set measurable objectives for improving safety.
- B. Actively request staff to periodically discuss their opinions, needs, perceptions of risks to patients and suggestions for improving safety. The actions taken as a result of this staff input will be reported to the MEC/GB annually.
- C. Use pre-established, objective process criteria to assess their effectiveness in improving patient safety.
- D. Draw conclusions based on their findings and develop and implement improvement in their activities.
- E. Evaluate their performance in supporting sustained improvement.
- F. The DQR will provide reports to the Governing Board at least quarterly. This report will include occurrences of patient safety events and other risk-related events, actions to improve patient safety, and other topics of interest to the Board.

*The DQR will report any sentinel event within the allotted timeframe to the Nevada Division of Public and Behavioral Health via "RedCap Application" along with reporting to corporate risk management.*

[Copy of Attachment E - Flow Diagram for Reviewable V Non-reviewable \(5\).xlsx](#)

Close

# **EYE SURGERY CENTER OF NORTHERN NEVADA:**

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## **QUALITY AND PATIENT SAFETY PLAN**

This plan was created and reviewed by ESCNN Patient Safety committee. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and/or preventable events.

## Commitment to Patient Safety

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ESCNN is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

### Mission, Vision, and Values

In support of our mission, vision, and values, ESCNN Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

## Scope and Purpose

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The scope of this Quality and Patient Safety Plan is organizational-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in ESCNN are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, ESCNN has developed this Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and

external customers, as well as facilitates the need of analyzing and improving processes.

The core principles of this plan include:

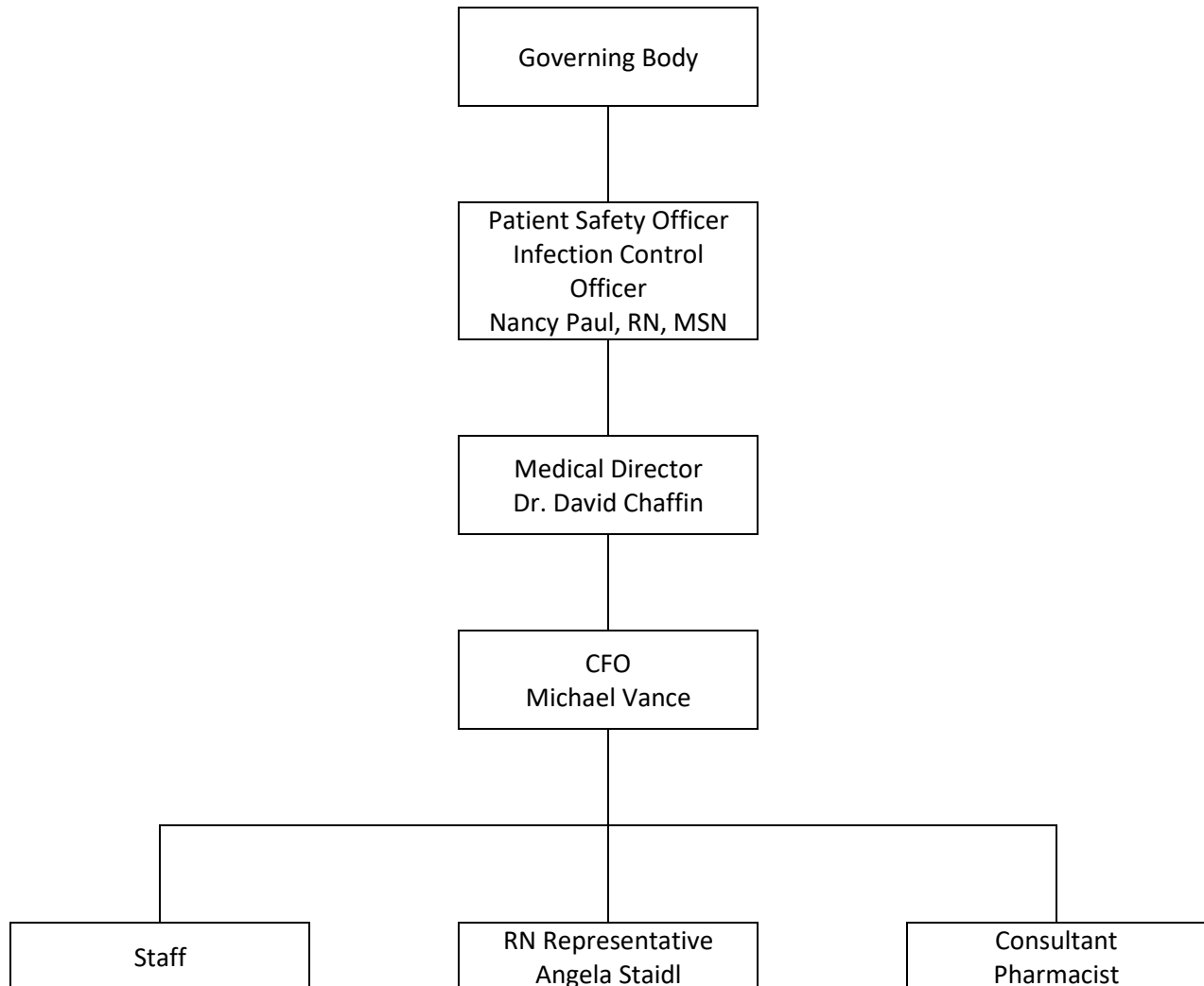
- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

## Roles and Responsibilities

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According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

### The Patient Safety Committee Organization





## Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below:

### Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

#### Root Cause Analysis (RCA) :

- Conduct RCA as needed utilizing members of the Patient Safety Committee.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.
- Make policy changes as needed based on RCA results.

#### Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

#### Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

#### Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

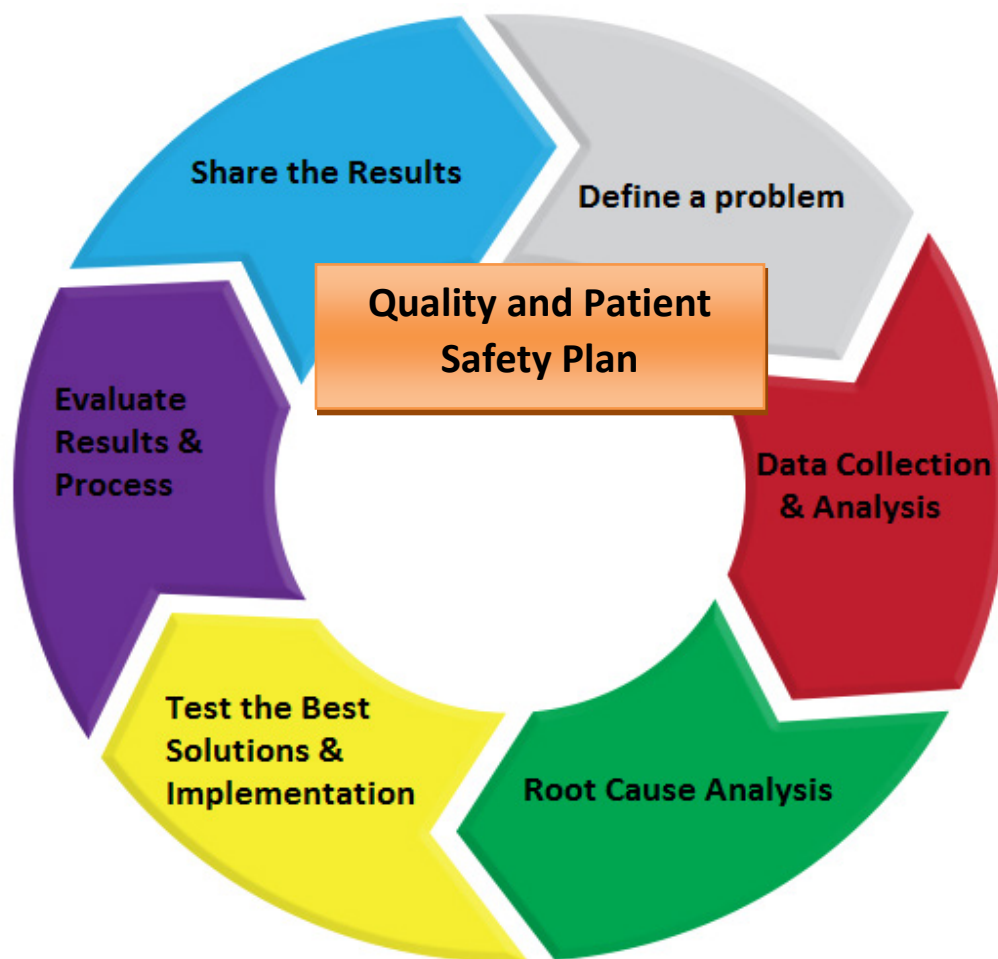
- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

## Components and Methods

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Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

ESCNN will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



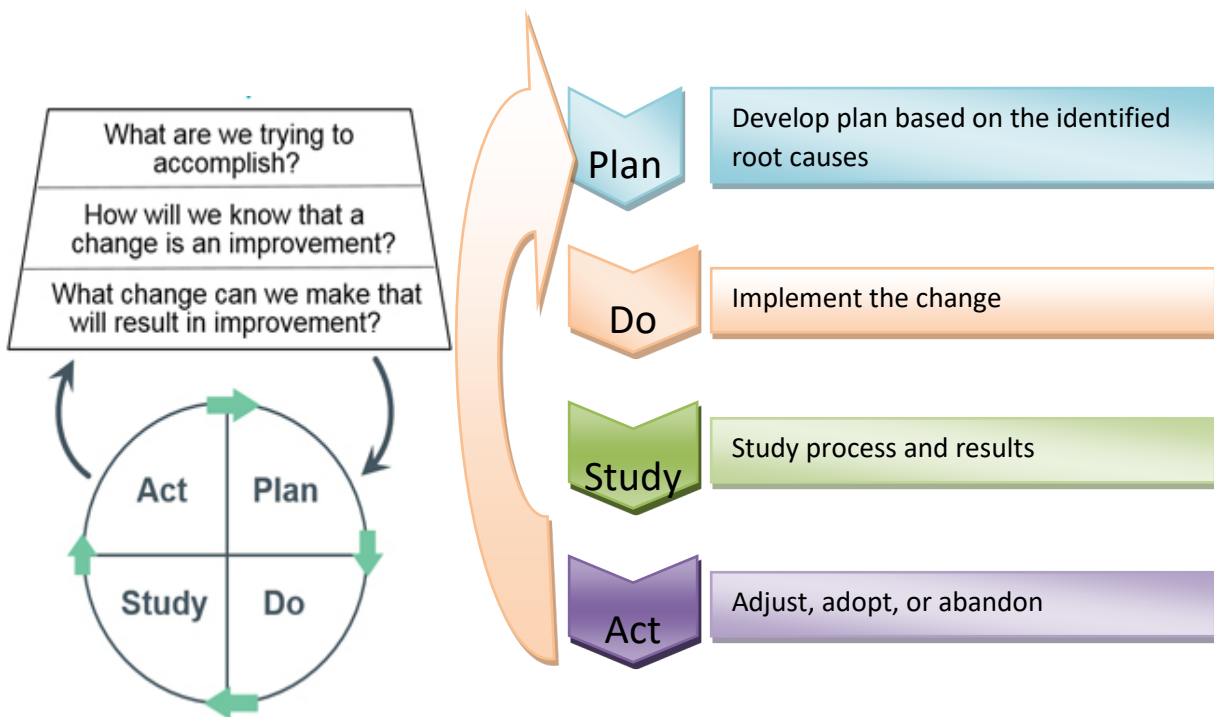
## Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

## Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
  - What is the objective of the test?
  - What are the steps for the test - who, what, when?
  - How will you measure the impact of the test?
  - What is your plan to collect the data needed?
  - What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

## Data Collection and Reporting

Data should drive any quality and patient safety effort. [ESCNN](#) is tracking sentinel events and healthcare infection data.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network

## Patient Safety Checklists and Patient Safety Policies

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By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA).

## Approval of Patient Safety Plan

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According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.



# Henderson Hospital Risk Management/ Patient Safety Plan

Revised 2/2020

## I. Overview

**Henderson Hospital** endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. Henderson Hospital operates a component listed Patient Safety Organization, the UHS Acute Care PSO, to further its commitment in promoting patient safety and assuring that UHS affiliated facilities remain at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by Henderson Hospital to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. The Risk Management/Patient Safety Plan ("Plan") provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems within each organization to which it applies. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the "Just Culture" concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is mainly utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with individual facility policies. Henderson Hospital employees, employees of acute care facilities, contractors, vendors, and members of each facility's medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

### **GENERAL STATEMENTS ON GOALS AND OBJECTIVES**

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.

- Evaluation and documentation of the effectiveness of actions implemented.
- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

## II. Mission and Vision

Henderson Hospital mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes; bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

Henderson Hospital recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

### III. ROLES AND RESPONSIBILITIES

#### A. A. Responsibilities for Patient Safety and Risk Management

**Henderson Hospital** has a designated risk director/manager responsible for patient safety risk identification and reduction for their respective facilities. Henderson Hospital is required to submit scheduled reports to the Insurance Department describing patient safety risk reduction efforts associated with facility specific risk areas quantified against industry or established benchmarks to assess exposures. Reports are thoroughly reviewed and analyzed by Department risk staff to determine effectiveness and follow-through of identified corrective action plans.

#### B. Patient Safety

UHSD operates the UHS Acute Care PSO, a listed component Patient Safety Organization, to support the patient safety activities at STHS. UHSD and STHS have established Patient Safety Councils (PSCs) to support patient safety activities. Each PSC should ensure that their respective Patient Safety Plan is promoted and executed successfully. STHS has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES include the Acute Care Division Corporate Patient Safety Council meetings and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to RiskConnect (STARS and Midas) to maintain and manage PSWP.

##### I. Henderson Hospital Patient Safety Council

**Henderson Hospital** has a Patient Safety Council (PSC) that meets on a regular basis and at least monthly.

##### Membership:

The committee core membership consists of 5 Key Members: (CEO, CNO, Physician, Risk, and Quality). The COO, CMO and Regional CMO are discretionary participants as applicable. The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

##### Duties and Responsibilities:

**Henderson Hospital** PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology:

- Issue Identification: The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history

unique to UHS facilities, patient safety concerns, industry claims, and through discussions with the corporate risk staff. Other issues may be related to process and corporate initiatives

- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue; a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the council is assured that it is truly the “Best Practice.”
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, The Joint Commission (Sentinel Event Alerts) and others, and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Council.

## **II. Patient Safety Advisories**

When an untoward event occurs at a facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, the Acute Care PSO distributes Safety Watch newsletters. These alerts detail the circumstances that lead to the negative outcome and facilities are charged with assessment and improvement of their own processes.

Henderson Hospital is required to address the Safety Watch newsletters via their Patient Safety Council and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement. In addition, Clinical Risk Alerts and Medication Safety Alerts are also formulated to apprise the facility of a specific safety issue that need to be assessed to prevent re-occurrence.

## **C. TERM Program**

The facility has utilized its formalized risk management program identified as TERM, or the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

**Element I: Administration of the Risk Management Program:** The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the UHS program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

**Element II: Risk Identification:** Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

**Element III: Risk Education:** Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

**Element IV: Patient Safety Initiative:** Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Council (PSC) at each facility. The council operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

**Element V: Patient Safety Priority: Root Cause Analysis (RCA):** The cornerstones of an effective patient safety and risk management program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

**Element VI: Environment of Care; Safety and Security Programs:** The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include: licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

**Element VII: Claims and Litigation Management:** The risk manager serves as the on-site representative of the corporate insurance program in the management of general and professional claims and litigation.

**Element VIII: UHS Acute Care Patient Safety Organization (PSO):** Facilities will designate key individuals to serve as participants in each Facility’s Member Workforce. Workforce participants are expected to perform identified patient safety activities on behalf of their Facility and to make regular reports to the Acute Care PSO. Workforce participants will be trained in their responsibilities and must also understand and

acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

#### **D. MIDAS**

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information and self-analysis can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for additional analysis and review.

#### **E. Risk Connect (STARS)**

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility and corporate staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership that includes metrics that assist in identifying strategies to facilitate risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by the facility's RM to the Governing Board of all claims activities.

#### **F. Event Notification Site**

The Risk Management Department developed the Event Notification Site or ENS, a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and UHSD management. Updates to the event are reported in real-time to all identified facility and corporate stakeholders via the ENS. The corporate risk management staff reviews each ENS to determine its completeness; follow-up is to be completed within 45 days.

## **G. Root Cause Analysis**

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that the Joint Commission's root cause analysis and action plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all the questions apply to all the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

### **RCA Responsibilities**

- Organize and coordinate the RCA process. For Serious OB events RCAs are to be done within 72 hours of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.





#### H. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)

The Patient Safety and Quality Improvement PSQIA of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well-trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

#### I. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related

to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired risk managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each risk manager is provided a copy of the corporate TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Corporate risk staff provides ongoing support and consultation to their assigned facility risk managers to facilitate the minimization of liability exposures and enhancement of safe patient care.

The corporate risk management staff provides consultative services to each facility and as members of corporate projects. These activities include on-site assistance, research, and consulting from off-site. Examples are as follows:

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories
- Clinical Risk Alerts
- Medication Safety Alerts

#### **IV. UHSD Acute Care Division Patient Safety Priorities, Goals and Objectives for 2020**

- Surgical and Procedural Safety:
  - Wrong Site Surgery.
    - Goal: A 50% reduction in WSS events for 2020. Ultimately the goal is 0
      - Monitor through Midas event reporting. Report monthly with oversight by CPSC.
  - Retained Procedural items (RPIs)
    - Goal: Prevent RPIs- a 50% reduction in RPIs with harm for 2020.. Ultimately the goal is 0 for RPIs
      - Monitor through Midas event reporting. Report monthly with oversight by CPSC.
- OBHRU:
  - Goal: Reduction/elimination of serious harm by reducing the response time to adverse obstetrical bleeding initiative.
    - As evidenced by:
      - Education Module X: All new hire staff and providers to complete Hemorrhage module within 1st 3 months of employment. All current staff and providers who care for perinatal patients to complete Hemorrhage module every 2 years (even years).

- Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results of Power Insights Hemorrhage report/dashboard.
  - All patients will receive POST BIRTH warning signs education for inpatient stay and discharge as evidenced by Power Insights report on education completion.
  - POST BIRTH collaborative benchmarking and assessment data from AWHONN/Premier collaborative
    - Monitor through Powers Insights QBL compliance report/Midas/ENS/Claims data, GNOSIS results, and facility education reports. Report monthly with oversight by CPSC
- CLABSI/CAUTI Initiative
  - Goal: CLABSI and CAUTI will both be reduced to less than the national CMS mean Standardized Infection Ratio (SIR: CLABSI 0.783; CAUTI 0.857) in 2020. .
    - Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly with oversight by CPSC.
- Safe Medication Use
  - Opioid Analgesic Event Reduction Initiative
    - Goal: decrease the number of preventable OIRD events by 10%
      - Monitor through MIDAS reports, Cerner ICD-10 codes and other intervention data. Report monthly with oversight by CPSC.
- Reduce Falls and Falls with Injury
  - Goal: 10 % reduction in the number of falls in the acute division by end of 2020.
    - Review of the progressive mobility (PM) documentation in the acute division
    - Correlation of PM documentation and fall incidents
    - Review of the documentation of PM in the ICU with LOS and length of intubation
    - Review of documentation of mobility and progression of mobility
      - Monitor through MIDAS event reporting. Report quarterly with oversight by CPSC.
- Culture of Safety
  - Goal: 100% of 2020 Patient Safety Plan Priorities will be implemented within the hospitals.
    - Monitor through MIDAS event reporting. Report monthly with oversight by CPSC.

- Telemetry Safety
  - Ensure communication between units and telemetry of all patient transfers.
    - Goal: decrease the number of events by 25% for 2020
      - Monitor through MIDAS reports, and other intervention data. Report monthly with oversight by CPSC.

## V. Monitoring and Accountability

### A. Evaluation of TERM Program

Corporate risk management provides site visits to each facility in a variety of ways. Some visits focus solely on a review of risk function and compliance with the TERM program. These evaluations consist of both a core risk and clinical risk review. Each facility is required to submit written corrective action plans for noted deficiencies determined during the TERM visit. All information is shared with senior staff at both the facility and the corporate level and monitored through the facility PSC.

### B. Patient Safety Council Coaching

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Council to the facility PSES site. The representative Corporate Risk Management staff review these minutes and provide detailed feedback to coach the councils on their form and function.

### C. Dashboard

The Patient Safety Dashboard includes multiple indicators to demonstrate each facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events or adverse drug events, serious harm OB events, and timeliness of event review and closure and Just Culture.

## VI. Evaluation/Review:

Corporate risk staff reviews the effectiveness of the corporate Patient Safety Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of "Near Miss" events
- The framework advances a "Just Culture" approach to patient safety
- Accountability is promoted when acts of "human error", "at risk", or "reckless behavior" are identified and corrected resulting in a reduction of potential/actual adverse outcomes

- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to CPSC for potential action from the corporate leadership team
- Review of annualized and prior year's probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line;
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis;
- Review information, analyses and reports from the Acute Care PSO for integration into the UHS of Delaware Patient Safety Evaluation System.

## **VII. Confidentiality and Annual Evaluation**

All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities. CPSC annually reviews the effectiveness of the UHS of Delaware, Inc. Safety Plan to ensure goals and objectives are appropriately focused on improving patient safety.

**SUBJECT:** Safe Environment Plan

**HORIZON SPECIALTY HOSPITALS  
HENDERSON/LAS VEGAS**

**DEPARTMENT:** Plant Operations/Safety

**SUBJECT:** Safe Environment Plan - 2017

## **I PURPOSE**

The purpose of the Safe Environment Plan is to provide a programmatic framework to reduce the risk to Horizon Specialty Hospitals. The plan includes processes that are designed to evaluate risks that may adversely affect the life or health of patients, staff and visitors.

### **Mission:**

Horizon Specialty Hospitals are committed to providing medically complex and rehabilitative care in a long-term acute care hospital environment to ensure quality care by using goal directed strategies, safe practices and teamwork to achieve optimal outcomes. The safe environment program is designed to support patient safety and effective care by providing reliable information that allows facility management and staff to make better safety decisions and to evaluate key issues and opportunities for improvement of safety performance.

Consistent with this mission, Horizon Specialty Hospitals have established and provides ongoing support for the safe environment program described in this plan.

## **II SCOPE**

The facility has an Environment of Care Committee (EOC) consisting of a cross representation of the facility's staff. The EOC monitors training and competence of staff and assesses conditions of the physical plant, grounds, and equipment through building inspections, environmental rounds, safety inspections and various performance improvement initiatives. Through review of reliable information, management is able to make the best decisions regarding safety concerns and to evaluate safety performance related to key issues with opportunities for improvement. The EOC monitors and evaluates all safety issues. It takes action and makes recommendations to the facility leadership, including the Administrator/Executive Officer, who is a member of the Governing Board. The EOC may issue assignments to committee members and non-committee staff for follow-up actions/improvements and completion of reports.

## **III FUNDAMENTALS**

- A. Safety is information driven. Without appropriate information, accident and incident causing situations cannot be predicted and prevented.
- B. Department managers need appropriate information to develop an understanding of safe working conditions and safe work practices within their area of responsibility.

**SUBJECT:** Safe Environment Plan

- C. Safe working conditions and practices are established by using knowledge of safety principles to: educate staff, evaluate existing conditions, design appropriate work environments and purchase appropriate equipment and supplies.
- D. The safe environment program establishes processes for identifying, evaluating and alleviating practices or situations that have a potential to harm patients, staff, or visitors or damage to property.
- E. The safe environment program establishes processes to reduce the occurrences, the probability and the effects of person-to-person violence.

**IV GOALS**

- A. Comply with accepted standards of safety.
- B. Provide a safe, secure and therapeutic environment for patients, staff and visitors.
- C. Integrate safety practices into daily operations.
- D. Identify opportunities to improve performance.

**V ORGANIZATION AND RESPONSIBILITY**

- A. The Administrator receives regular reports on activities of the safety program from the EOC. The Administrator reviews reports and, as appropriate, communicates safety related concerns about identified issues and regulatory compliance.
- B. The Administrator reviews reports and, as necessary, communicates concerns about key issues and regulatory compliance to appropriate departments, services and staff. The administration collaborates with appropriate departments, services and staff to establish operating and capital budgets for the safe environment program.
- C. The Safety Officer (SO) has responsibility for identification, collection and analysis of information regarding safety deficiencies, development of plans for improvement, accident and injury prevention and investigation, and emergency response. Training of staff and volunteers is facilitated by the Director of Plant Operations.
- D. The EOC coordinates processes within the Environment of Care Standards. Membership on the EOC is by appointment from the Administrator and includes representatives from administration, clinical services and support services. The EOC meets as often as is necessary on a regular basis to receive reports and to conduct reviews of safety issues. Additional meetings may be scheduled at the request of the Safety Officer.

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016

**SUBJECT:** Safe Environment Plan

- E. The Administrator authorizes key staff to take immediate and appropriate action in the event of an emergency. An emergency is a situation that poses an immediate threat to life or health, or threatens to damage equipment or buildings.
- F. Department managers are responsible for the orientation of new staff members to the department, program and job specific safety procedures.
- G. Individual staff members are responsible for learning and following job and task specific procedures for safe operations. Individual staff members are also responsible for learning and using reporting procedures.

## **VI PROCESSES OF THE SECURITY PROGRAM**

### **A. Risk Assessment**

The Horizon Specialty Hospitals Safety officer is responsible for managing the safe environment program risk assessment process. When issues arise the Safety Officer will consult with the Administrator in regard to approval for actions or guidance.

1. Horizon Specialty Hospitals pro-actively performs risk assessments in a manner that allows for comprehensive evaluation of existing aspects of the organization, and the impact of proposed changes. The goal of risk assessment is to reduce the likelihood of future incidents that have the potential for injury, accident, or other loss to patients, staff, visitors and facility assets.
2. Horizon Specialty Hospitals address other environmental considerations when performing risk assessment functions. For example, when planning demolition, construction, or renovation work, the facility conducts a proactive risk assessment using risk criteria to identify hazards that could potentially compromise patient care in occupied areas of the facility buildings.

Use of the risk assessment process triggers organization linkages with other aspects of the safe environment program. For example, a proposed change may indicate a need to create or revise existing safety policies and procedures; hazard surveillance in the areas affected; safety orientation and education programs; and safety performance improvement monitoring. Horizon Specialty Hospitals' SO is responsible for coordinating the impact of proposed changes with other aspects of the safe environment program.

Horizon Specialty Hospitals' SO and department managers are responsible for performing follow-up activities on issues, findings, observations or recommendations that result from applying the risk assessment process. Horizon Specialty Hospitals' EOC reviews reports related to the safe environment program risk assessment processes.

### **B. Reporting and Investigating**

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016



**SUBJECT:** Safe Environment Plan

The safe environment program uses a variety of reporting methods to document activities. The SO, Risk Manager, Chief Nursing Officer/Chief Operations Officer (CNO/COO) and Human Resources Director share responsibility for managing, reporting and investigating incidents.

Reports of patient and visitor incidents/accidents are made using the appropriate forms. These reports are reviewed by the EOC, QAPI and Infection Control. Aggregate information is reviewed by the EOC.

Reports of significant property damage are directed to the SO.

One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

**C. Hazard Surveillance**

The Director of Plant Operations (DOPO) is responsible for managing the hazard surveillance process including product safety recalls. Hazard surveillance surveys are conducted to evaluate staff knowledge and skill, EOC compliance, observe current practices, assess/evaluate environmental conditions and other risk factors. Results of hazard surveillance activities serve to improve safety policies and procedures, risk assessments, orientation and education programs and staff performance.

Surveys are conducted on a frequency that meets the needs and requirements of the various areas that are surveyed. All inpatient care areas are scheduled for at least two annual hazard surveillance surveys. Non-patient care areas are scheduled for at least one hazard surveillance survey each year. Areas or systems under special circumstances are scheduled for additional surveys as required.

Additional hazard surveillance surveys are performed during the application of Interim Life Safety Measures (ILSM). Hazard surveillance surveys to assure free and unobstructed exiting for construction projects are performed daily.

The EOC Committee is responsible for oversight of the hazard surveillance program. This includes ensuring that the information received includes an analysis of data collected, identification of trends and patterns, risk reduction strategies, corrective action recommended or taken and persons responsible.

Individual department managers are responsible for initiating appropriate action on findings applicable to their scope of authority or responsibility. The SO is responsible for coordinating follow-up activities with individual department managers to ensure each finding is brought to closure.

**D. Environment of Care Committee**

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016

**SUBJECT:** Safe Environment Plan

The EOC includes selected members of administration, clinical and support services.

The Safety Officer through the EOC is responsible for managing the process of examining safety issues. Effective use of information is dependent on written and verbal reports from a number of different functions within Horizon Specialty Hospital. Reports are used to identify and communicate problems, time-sensitive issues and general information about periodic or structured activities to the EOC. Reports help the EOC to prioritize, develop and approve recommendations for improvement of patient, staff and visitor safety. It is the responsibility of the EOC Chairperson to review the content of reports submitted.

The EOC processes information via a discussion of findings and recommendations outlined in the minutes for each meeting. The minutes also document recommendations the EOC has developed and otherwise approved.

E. Performance Improvement Monitoring

The SO through the EOC Committee has overall responsibility for coordinating the ongoing performance monitoring and the performance improvement monitoring for each of the seven functions associated with Management of the Environment of Care. The SO is responsible for all monitoring associated with the safe environment program.

The intent of establishing performance monitoring is to improve the safe environment program through objective measures of demonstrated performance. The results of measurement are reported through appropriate channels including the facility's leadership and when appropriate to relevant components of the facility wide patient safety program. Performance improvement is an important aspect of the Safe Environment Plan. Ongoing performance monitoring serves as an indicator of continued effectiveness of the safe environment program and is a mechanism to identify performance improvement opportunities.

F. Policies and Procedures

The SO has overall responsibility for coordination of the EOC policy and procedure process including coordination with individual department managers.

Individual department, program, and site managers are responsible for their specific safety policy and procedure process. These safety policies and procedures address issues such as: safe operations, use of hazardous equipment or processes and use of personal protective equipment. The SO assists department managers in development of new safety policies and procedures and participates in reviewing existing policies and procedures.

Organization-wide safety policies and procedures are communicated to staff via normal communication channels. Department managers are responsible for distribution of safety policies and procedures and ensuring they are enforced. Each staff member is responsible for knowing and following all safety policies and procedures.

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016

**SUBJECT:** Safe Environment Plan

Both facility-wide and departmental, program and site safety policies and procedures are reviewed at least every three years. Additional interim reviews are performed on an as needed basis.

Horizon Specialty Hospital has established a procedure for implementing new policies, procedures and practices. Administrative policy determines the form, structure and organization of all policies, procedures and practices.

**G. Safety Officer Appointment**

The Administrator is responsible for managing the Safety Officer Appointment process.

The Administrator is responsible for selecting a qualified individual who is capable of overseeing the development, implementation and monitoring of the safe environment program. By appointment, the SO is assigned overall operational responsibility for the safe environment program. The SO is made known to all staff through normal communication channels.

The SO is accountable to the Administrator and is guided by a written duty description. For example, the SO reviews changes in law, regulation and standards; assesses the need to make changes to general safety, procedures, training; and performs other activities essential to the implementation of the safe environment program.

The SO directs the integration of environment of care monitoring and response activities into the hospital-wide patient safety program.

**H. Immediate Threat Statement**

The Administrator is responsible for managing the process for identifying individual(s) who may intervene whenever conditions pose an immediate threat to life or health or threatens damage to equipment or buildings.

To support this process an Immediate Threat Statement is defined in the Situation Response and Crisis Communication Manual. This policy is intended to define authority and responsibility in situations that pose an immediate threat; to the life or health of patients, staff and visitors; or risk major damage to buildings or property. The goal of the Immediate Threat Statement is to identify and mitigate an immediate threat situation before such situation results in loss and to return the facility to normal conditions as quickly as possible.

Key staffs are empowered to intervene immediately and to take appropriate action(s) to mitigate the effects of such situations. Such delegation of authority enables the facility to implement the policy, swiftly and decisively, on a twenty-four hours a day/seven days a week basis.

The Immediate Threat Statement is approved by the Administrator; is revised as necessary and reviewed at least every three years.

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016

**SUBJECT: Safe Environment Plan**

**I. Grounds and Equipment**

The DOPO is responsible for managing the facilities grounds and external equipment maintenance processes. The Horizon Specialty Hospital provides patient care, treatment or activities outside of facility buildings. There are patient activities conducted outside of facility buildings that require supervision by facility staff.

The DOPO is responsible for scheduling and performing maintenance to facility's grounds and external equipment. DOPO makes regular rounds of various areas to observe and correct conditions and ensure safety of facility's grounds and external equipment.

Facility grounds includes for example: courtyards, shrubs and trees, sidewalks, roadways, parking lots, lighting, signage and fences. External equipment includes for example: electrical switch gear, transfer switches, and fuel storage. The nature of these types of external equipment is such that limited or infrequent preventive maintenance is required. Corrective maintenance is completed on an as needed basis.

**J. Annual Evaluation**

The SO has overall responsibility for coordinating the annual evaluation of each of the seven functions associated with management of the Environment of Care. The SO is responsible for completing the annual evaluation of the safe environment program. An evaluation of the program's objectives, scope, performance, effectiveness and the Safe Environment Plan is included in each annual evaluation.

In the completion of the annual evaluation, the SO utilizes a variety of source documents such as policy review and evaluation, incident report summaries, risk assessment activities, meeting minutes and statistical information summaries. In addition, other relevant sources of information are used for the annual evaluation, such as results of monitoring studies, reports from accrediting and certification agencies and goals and objectives. The annual evaluation of the security program is used to further develop educational programs, policies, performance monitoring and improvement.

The annual evaluation is reviewed and approved by the EOC. The annual evaluation is then presented to the Performance Improvement Committee, Executive Management Committee, Medical Executive Committee and Governing Board. Minutes or other means of communications from the Governing Board are received, reviewed and acted upon the by the EOC.

**VII WORKER SAFETY**

The EOC and Infection Control Committee are responsible for identifying activities to reduce the risk of staff/worker injuries.

**A. Reporting and Investigating**

The safe environment program uses a variety of reporting methods to document activities. The SO, Risk Manager and Human Resource Director share responsibility for managing,

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016

**SUBJECT:** Safe Environment Plan

reporting and investigating incidents of injuries, occupational illnesses and accidents. Reports are made using the appropriate forms. This information is reviewed by the EOC, QAPI and Infection Control. Aggregate information is reviewed by the EOC.

One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

**B. Orientation and Education**

The Director of Plant Operations has overall responsibility for organizing the orientation and education program for each of the seven functions associated with Management of the Environment of Care. Department managers are responsible for assuring the safe environment program orientation and education is implemented.

The Director of Plant Operations is responsible for conducting the general orientation program with current information on general safety processes to new staff members as soon as possible but within 30 days of employment. Every new staff member participates in a general orientation program that includes information related to the safe environment program. Critical Environment of Care information is provided prior to staff being allowed to work independently. The Human Resource Department records attendance for each new staff member who completes the general orientation program. Attendance records are maintained in the Education and Human Resource Department.

Each department manager is responsible for providing their new staff members with safe environment orientation specific to their department. The goal of these orientation programs is to provide new staff members with current job specific safety and hazard information.

All staff members of the facility must participate in mandatory continuing education at least once each year, which includes information specific to the safe environment program. This requirement may be satisfied through completion of a self-learning packet or attendance at a regularly scheduled facility-wide continuing education program. The Human Resource and Education Departments maintains records of all completed training.

Various Departments collaborate with the Facilities Department and individual managers, as appropriate, for developing content and supporting material for general and department specific orientation and continuing education programs. The content and supporting materials utilized are reviewed and revised as necessary.

The Human Resource Department reports information on orientation and continuing education data during the reporting period to the EOC.

## **VIII SMOKING**

Horizon Specialty Hospitals have a policy to reduce the risks to patients who smoke, including possible adverse effects on treatment; risks of passive smoke to others; and risks of fire

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016

**SUBJECT:** Safe Environment Plan

Patients, staff and visitors are prohibited from smoking in all facility regulated buildings and campus.

Original: 06/2003

Reviewed/Revised: 12/2009, 3/2010, 3/2010, 1/2011, 1/2012, 1/2013, 2014, 12/2015, 12/2016

**HUMBOLDT GENERAL HOSPITAL  
CRITICAL ACCESS HOSPITAL  
118 East Haskell St.  
Winnemucca, Nevada 89445**

**POLICY/PROCEDURE**

**Date:**

**Revised:**

**Developed by: Quality Services Director**

**Revised by:**

**Department: All HGH Departments**

**Page 1 of 1 Page**

**Reviewed by:** \_\_\_\_\_

**Approved:** \_\_\_\_\_

**Approved:** \_\_\_\_\_

**Effective:** \_\_\_\_\_

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**POLICY:**

**PATIENT SAFETY PLAN**

In compliance with NRS 439.800-439.890, Humboldt General Hospital shall develop, in consultation with the providers of health care who provide treatment to patients at the medical facility, an internal patient safety plan to improve the health and safety of patients who are treated at this medical facility.

HGH shall develop a patient safety plan to include without limitation:

- a) The patient safety checklists and patient safety policies most recently adopted pursuant to NRS 439.877.
- b) An infection control program to prevent and control infections within the medical facility. To carry out the program, HGH shall adopt an infection control policy. The policy must consist of:
  - 1) The current guidelines appropriate for HGH's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, without limitation, the Association for Professionals in Infection control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United State Department of Health and Human Services, The World Health Organization and the society for Healthcare Epidemiology of America: and
  - 2) Facility-specific infection control developed under the supervision of a certified infection preventionist.

HGH shall designate the house supervisors as the person who is responsible for infection control when the infection control officer is absent to ensure that someone is responsible for infection control at all times.

The Patient Safety Plan shall be submitted to the governing board for approval in accordance with the requirements of NRS 439.865. After the HGH Patient Safety Plan is approved, all providers of health care who provide treatment to patients at HGH shall be notified of the plan and of the requirements of the plan. Compliance with the HGH Patient Safety Plan shall be required.

The Patient Safety Plan shall be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

HGH shall designate an employee to serve as the patient safety officer. The person who is designated as the patient safety officer shall:

- a) Serve on the Patient Safety Committee

- b) Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- c) Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at HGH.
- d) Report to the patient safety committee regarding any action taken in accordance with paragraph (c).

HGH shall designate an employee to serve as the infection control officer. The infection control officer shall:

- a) Serve on the patient safety committee.
- b) Monitor the occurrences of infections at Humboldt General Hospital to determine the number and severity of infections
- c) Report to the patient safety committee concerning the number and severity of infections at HGH. Take such action as he or she determines is necessary to prevent and control infections alleged to have occurred at HGH.
- d) Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

HGH will ensure that the infection control officer has successfully completed a nationally recognized basic training program in infection control, which may include, without limitation, the program offered by the Association for Professionals in Infection Control and Epidemiology, Inc., or a successor organization. The infection control officer shall complete at least 4 hours of continuing education each year on topics relating to current practices in infection control and prevention. HGH shall maintain records concerning the certification and training required by this section.

HGH shall establish a patient safety committee.

- a) The HGH Patient Safety Committee must be composed of:
  - 1) The patient safety officer of the medical facility.
  - 2) The infection control officer of the medical facility.
  - 3) At least three providers of health care who treat patients at HGH, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.
  - 4) One member of the executive or governing body of the medical facility.
- b) A patient safety committee shall meet at least once each month.
- c) The patient safety committee shall:
  - 1) Receive reports from the patient safety officer pursuant to NRS 439.870.
  - 2) Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
  - 3) Review and evaluate the quality of measures carried out by HGH to improve the safety of patients who receive treatment at the medical facility.
  - 4) Review and evaluate the quality of measures carried out by HGH to prevent and control infections at the medical facility.
  - 5) Make recommendation to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at HGH.
  - 6) At least once each calendar quarter, report to the HGH executive or governing body of the medical facility regarding



- i. The number of sentinel events that occurred at HGH during the preceding calendar quarter;
  - ii. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
  - iii. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- 7) Adopt patient safety checklists and patient safety policies as required, review the checklists and policies annually and revise the checklists and policies as the patients safety committee determines necessary.
- d) The proceedings and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265

The Patient Safety Committee, established pursuant to NRS 439.875 by a medical facility, shall adopt patient safety checklists and patient safety policies for use by:

- a) Providers of health care who provide treatment to patients at HGH;
- b) Other personnel of the medical facility who provide treatment or assistance to patients;
- c) Employees of the HGH who do not provide treatment to patients but whose duties affect the health or welfare of the patients at HGH, including, without limitation, a janitor or HGH; and
- d) Person with whom HGH enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at HGH.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- a) Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
- b) Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
- c) A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - 1) Proper instructions concerning prescription medications;
  - 2) Instructions concerning aftercare; and
  - 3) Any other instruction concerning his or her care upon discharge.
- d) Any other checklists which may be appropriate to ensure the safety of patients at the medical facility

The patient safety policies must include, without limitation:

- a) A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of health care. The personal identifiers may include, without limitation, the name and date of birth of the patient.

- b) A policy regarding the nationally recognized standard of precautionary protocols to be observed by providers of health care at the medical facility including, without limitation, protocols relating to hand hygiene.
- c) A policy to ensure compliance with the patient safety checklists and patient safety policies, which may include, without limitation, active surveillance. Active surveillance may include, without limitation, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

The Patient Safety Committee shall:

- a) Monitor and document the effectiveness of the patient identification policy adopted.
- b) At least annually, review the patient safety checklists and patient safety policies adopted pursuant to this section as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
- c) On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if the person, without malice:

- a) Reports a sentinel event to a governmental entity with jurisdiction or another appropriate authority;
- b) Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event;
- c) Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority;
- d) Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or
- e) Performs any other act authorized pursuant to [NRS 439.800](#) to [439.890](#), inclusive.

If Humboldt General Hospital:

- (a) Commits a violation of any provision of [NRS 439.800](#) to [439.890](#), inclusive, or for any violation for which an administrative sanction pursuant to [NRS 449.163](#) would otherwise be applicable; and
- (b) Of its own volition, reports the violation to the Administrator, such a violation must not be used as the basis for imposing an administrative sanction pursuant to [NRS 449.163](#).

If HGH commits a violation of any provision of [NRS 439.800](#) to [439.890](#), inclusive, and does not, of its own volition, report the violation to the Administrator, the Division may, in accordance with the provisions of subsection 3, impose an administrative sanction:

- (a) For failure to report a sentinel event, in an amount not to exceed \$100 per day for each day after the date on which the sentinel event was required to be reported pursuant to [NRS 439.835](#);
- (b) For failure to adopt and implement a patient safety plan pursuant to [NRS 439.865](#), in an amount not to exceed \$1,000 for each month in which a patient safety plan was not in effect; and
- (c) For failure to establish a patient safety committee or failure of such a committee to meet pursuant to the requirements of [NRS 439.875](#), in an amount not to exceed \$2,000 for each violation of that section.



# 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%.

2016

- ✦ 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.



# QUALITY AND PATIENT SAFETY PLAN

Lake's Crossing Center

500 Galletti Way  
Sparks, NV 89431  
775-688-1900



### **Commitment to patient safety**

Lake's Crossing Center provides statewide residential and outpatient services to individuals who have been evaluated as requiring mental health services in order to proceed with their adjudication. Such services require a fully coordinated effort with responsibilities for treatment, evaluation and consultation. Lake's Crossing Center must meet a wide range of needs for a diverse population and we are committed to a comprehensive approach for continuous improvement of patient safety.

### **Mission, Vision and Values**

The purpose of this policy is to establish a plan for patient safety designed to promote patient safety throughout all departments in Lake's Crossing Center. Thus, the plan will focus on system-wide integrated performance improvement activities aimed at assuring an integrated approach to patient safety. In support of our commitment to patient safety, Lake's Crossing Patient Safety and Quality Improvement program includes oversight regarding:

- Providing the necessary services to clients in the least restrictive manner appropriate to the client, utilizing collaboration of leadership, medical staff and other staff providers to deliver integrated and high quality care within the program.
- Consultation and collaboration with other Division agencies on the treatment and management of clients.
- Providing treatment oriented toward development of socially appropriate and community -oriented skills stabilizing potentially dangerous behavior.
- Ensuring appropriate placement and follow-up of clients adjudicated not guilty by reason of insanity or un-restorable to competency.
- Continuing education of staff and medical personnel to assure quality of care and monitoring of standards.

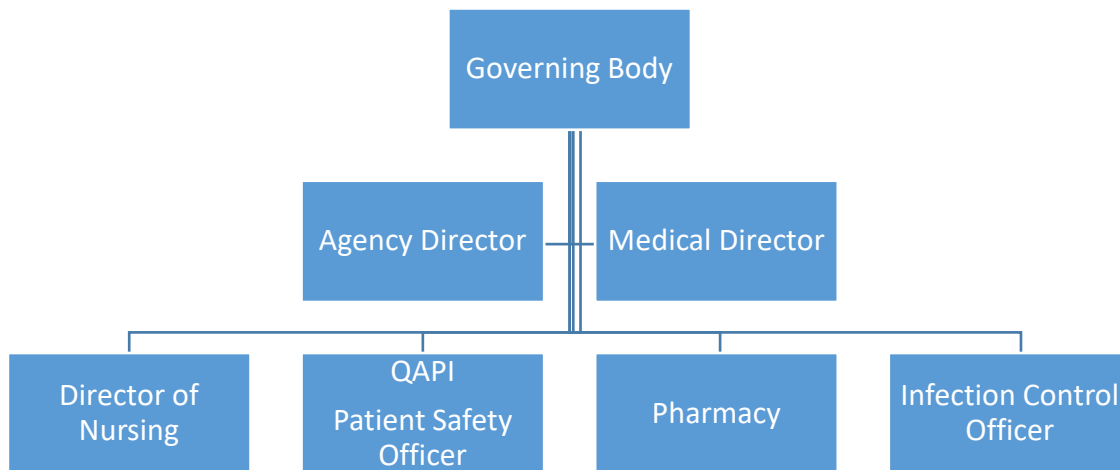
### **Scope and Purpose**

The scope of the Patient Safety Plan is agency wide and includes all aspects of patient safety, visitor safety, vendor safety and employee safety. All staff in Lake's Crossing are required to fully support and participate in this plan and devote their expertise to the patient safety and quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the clients and facilitate our accountability to the courts. The plan further focuses on the processes involved and facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions regarding implementations of the Patient Safety Plan will be based on data and facts and will be reported to and tracked by the QAPI department.

*As per NRS 439.875, a medical facility shall establish a Patient Safety Committee. This Patient Safety Committee should ensure that the Quality and Patient Safety Plan is promoted and executed successfully. The Patient Safety Committee organizational chart for Lake's Crossing is as follows:*



**Roles and Responsibilities of the Patient Safety Committee:**

- Meet at least once a month
- Receive reports from the Patient Safety officer as per NRS 439.870
- Evaluate the actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at Lake's Crossing.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of clients who receive care at Lake's Crossing.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections at Lake's Crossing.
- Make recommendations to the governing body to reduce the possible number and severity of sentinel events and infections that could occur at Lake's Crossing.
- Report to the governing body at least once each quarter regarding the number of sentinel events occurring at Lake's Crossing during the preceding calendar quarter; the number and severity of infections that occurred at Lake's Crossing during the preceding calendar quarter; any identified recommendations to reduce the number and severity of any sentinel events and infections that occur at Lake's Crossing.

- Adopt and put into use, patient safety checklists and patient safety policies, as required in NRS 439.877, review the checklists and policies annually and revise as determined by the patient safety committee.
- On or before March 1 of each year, submit a report to the Director of the Legislative Counsel Bureau that will be transmitted to the Legislative Committee on Health Care. This report is to include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review.

#### **Roles and Responsibilities of the Patient Safety Officer:**

- Serve on the Patient Safety Committee
- Conduct root cause analysis through utilization of interviews, analysis, investigation and corrective action plan implementations.
- Perform the duties as required in NRS 439.835 regarding the reporting of sentinel events.
- Take such action as is determined to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at Lake's Crossing.
- Report to the Patient Safety Committee regarding any action taken in accordance with the above responsibilities.

#### **Roles and Responsibilities of the Infection Control Officer:**

- Serve on the Patient Safety Committee
- Monitor the occurrences of infections at Lake's Crossing to determine the number and severity of infections.
- Report to the Patient Safety Committee concerning the number and severity of infections at Lake's Crossing
- Take such action as is determined to prevent and control infections as identified at Lake's Crossing.
- Carry out the provisions of the infection control program pursuant to NRS 439.865 and ensure compliance with the program.

#### **Roles and Responsibilities of the Governing Body**


- Provide vision, leadership and oversight to the Patient Safety and Quality Improvement process and develop and foster a safe learning and improving culture at Lake's Crossing.
- Plan, discuss, and work with the committee and its members in accomplishing the patient safety goals and activities.

### Objectives, Goals and Assessment of the Quality and Patient Safety Plan

Pursuant to NRS 439.837, Lakes Crossing will utilize the proper procedures to report any sentinel events and conduct an investigation concerning the causes or contributing factors and implement a plan to remedy the causes or contributing factors of the sentinel event through the use of Root Cause Analysis. Also considered for analysis will be near misses, repeated problems such as medication errors and events which have or could have resulted in patient harm. The objective will be to determine where gaps lie and how to determine them; not to place a blame in any particular department or individual.

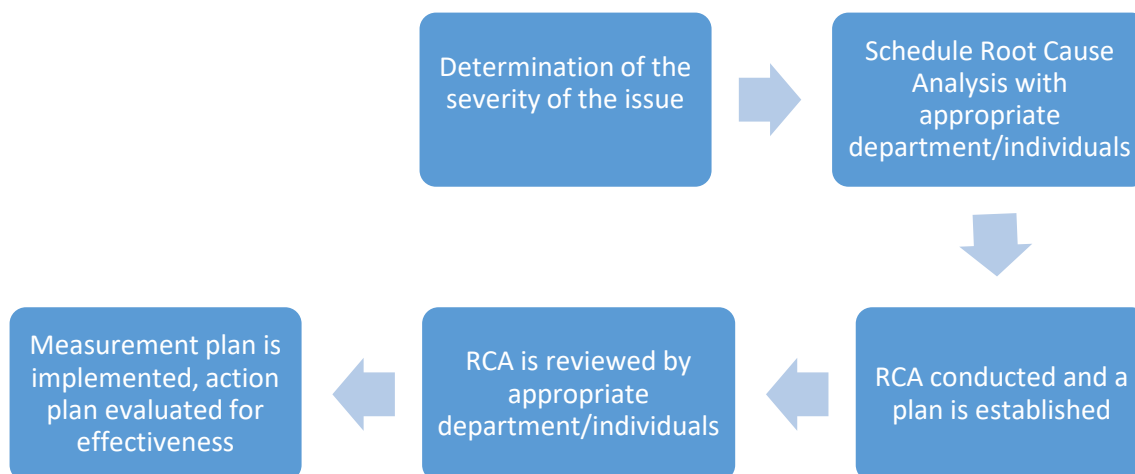
The event will be analyzed based on the factors of *catastrophic, major, moderate and minor*. The probability will be measured on the frequency – is it a frequent occurrence, occasional occurrence, uncommon occurrence or remote occurrence.

**TABLE 1: Safety Assessment Matix**

| Severity  | Catastrophic | Major | Moderate | Minimal | Comments |
|--------------------------------------------------------------------------------------------|--------------|-------|----------|---------|----------|
| Frequent                                                                                   | 3            | 3     | 2        | 1       |          |
| Occasional                                                                                 | 3            | 2     | 1        | 1       |          |
| Uncommon                                                                                   | 3            | 2     | 1        | 1       |          |
| Remote                                                                                     | 3            | 2     | 1        | 1       |          |

The above matrix will be used as a determining factor for if a Root Cause Analysis would be necessary for the incident with “3” being the highest rating.

Upon identification of an incident necessitating a Root Cause Analysis a meeting will be held with determination steps as follows:



According to NRS 439.865, the patient safety plan must include certain required checklists relating specifically to our facility. The specific checklists which are **required** to be included are listed below as well as others pertinent to Lake's Crossing Center.

**Patient Safety Checklists and Patient Safety Policies:**

| Check Lists Include:                                          | Usage                    | Existing | Developed | Reviewed | Revised   |
|---------------------------------------------------------------|--------------------------|----------|-----------|----------|-----------|
| Documentation of physician orders LCC Policy 5.200            | Nursing                  | Yes      | Yes       | 6/2019   | 6/2019    |
| Discharged client room cleaning inspection                    | Janitorial               | yes      | Yes       | Monthly  |           |
| Discharge instructions LCC Policy 5.104                       | Nursing, Social Services | Yes      | Yes       | 6/2019   | 6/2019    |
| Pharmacy error tracking                                       | Pharmacy                 | yes      | Yes       | Monthly  |           |
| Fall Prevention                                               | Nursing                  | yes      | Yes       | Monthly  |           |
| Sanitation QA checklist                                       | Janitorial               | yes      | Yes       | Monthly  |           |
| Food service meal incident communication log                  | Nutritional Services     | Yes      | Yes       | Weekly   |           |
| Eyewash station                                               | Janitorial               | Yes      | Yes       | 6/2019   |           |
| Chemical sanitizing dish machine log                          | Nutritional Services     | Yes      | Yes       | Yes      |           |
| Refrigerator & freezer logs                                   | Nutritional Services     | Yes      | Yes       | Yes      |           |
| Pre-clozapine workup                                          | Nursing                  | Yes      | Yes       | yes      |           |
| Patient Safety Policies Include:                              | Usage                    | Existing | Developed | Reviewed | Revised   |
| Two personal patient identifiers                              | All Staff                | yes      | Yes       | 6/2019   | 6/2019    |
| Nationally recognized standard precautions protocol LCC 5.408 | All staff                | Yes      | Yes       | 6/2019   |           |
| Nationally recognized hand washing procedures LCC 5.408       | All staff                | Yes      | Yes       | 6/2019   |           |
| Infection control policies Lcc 5.41-5.438                     | Nursing                  | yes      | Yes       | 6/2019   | As needed |

| Summary of Review         | Total # Developed | Total # Reviewed | Total # Revised |
|---------------------------|-------------------|------------------|-----------------|
| Patient Safety Checklists | 1                 | 11               | 2               |
| Patient Safety Policies   |                   | 4                | 2               |



**Ongoing Reporting and Review:**

| Monthly                                                                                                                                                                                                                      | Quarterly                                                                                                                                                                                                                                                                                              | Annually                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>1) Sentinel Event monthly report</li> <li>2) Severity of infection report</li> <li>3) Meeting of the Patient Safety Committee</li> <li>4) Monitoring of contract personnel</li> </ul> | <ul style="list-style-type: none"> <li>1) Sentinel Event quarterly report</li> <li>2) Severity of infection quarterly report</li> <li>3) Review and evaluate the measure of improvement of patient safety</li> <li>4) Review and evaluate the measurement to prevent and control infections</li> </ul> | <ul style="list-style-type: none"> <li>1) Report submitted to LCB</li> <li>2) Quality and Patient Safety plan update</li> <li>3) Checklists and policies reviewed and revised as necessary</li> </ul> |

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### **Purpose**

To establish the role of hospital leadership, hospital staff and medical staff in an intergraded patient safety program.

### **Policy**

Hospital leaders ensure that an integrated patient safety program is implemented throughout the hospital and ensure the participation of hospital staff and medical staff in the Patient Safety Program.

### **Procedure**

- A. A patient safety program is established throughout the hospital. A qualified individual or team is assigned to manage the hospital safety program.
- B. The scope of the patient safety program encompasses potential negative to actual negative and serious events (near misses to sentinel events).
- C. All components of the hospital participate in the patient safety program.
- D. Patient Safety Program Reports are presented at least annually to the Governing Board regarding system or process failures and actions taken to improve patient safety



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## **Patient Safety Program**

### **Addendum to the Performance Improvement Plan**

#### **Purpose**

LifeCare Hospitals \_\_\_\_\_ has developed a Patient Safety Program in conjunction with the Performance Improvement Plan and Program, the Risk Management Plan and Program and the Hospital Scope of Services, in order to provide guidelines for implementation of an integrated patient safety program throughout the hospital. It is the intent of the leadership of LifeCare Hospitals of \_\_\_\_\_ to foster a safe and safety-conscious environment that promotes well being, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvement.

#### **Scope**

Overall Patient Safety Goals include the following:

1. Improve the accuracy of patient identification
2. Improve the effectiveness of communication among caregivers
3. Improve the safety of using high-alert medications
4. Eliminate wrong-site, wrong patient and wrong-procedure surgery
5. Improve the safety of using infusion pumps
6. Improve the effectiveness of clinical alarms systems
7. Ensure the prevention and control of infections

The primary focus of the Patient Safety Program is the patient; however the program also addresses the safety of visitors and staff from all clinical and organizational functions. The scope of the Patient Safety Program includes but is not limited to the occurrence of the following:

1. Adverse Drug Reactions
2. Falls
3. Restraints
4. Medication Errors
5. Hazardous Condition(s)
6. Near Misses
7. Sentinel Events

#### **Methodology**

The Patient Safety Program includes both pro-active and responsive components.

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**Proactive:** The proactive patient safety component emphasizes a pro-active error reduction and avoidance program. The following will be reviewed to proactively identify patient safety issues:

1. Medical equipment and medication risk assessment activities
2. Sentinel event alert risk reduction activities
3. Performance improvement indicators and monitoring activities
4. Patient Satisfaction reports
5. Medical record review reports
6. Staff orientation, evaluation, training, and education activities
7. Failure Mode and Effect Analysis (FMEA) activities
8. Medical Staff Credentialing issues
9. Occurrence Report Trending

Failure Mode Event Analysis (FMEA) will be conducted annually. The process to be studied each year will be determined in collaboration with medical staff, hospital leadership and staff. Information from patient safety organizations such as the Institute for Medicine, Institute for Safe Medication Practices, and the Joint Commission will be disseminated to the appropriate departments and committees for action and implementation of recommendations.

**Responsive:** The hospital will utilize information gathered from risk assessments, sentinel event alerts, performance improvement measures, medical record review, and other data in order to track, trend, and respond to patient safety issues. Patient safety related issues will be ranked based on severity. The following will be reviewed for reactive patient safety issues:

1. Root Cause Analysis
2. Intensive Assessment and Analysis
3. Occurrence Report Findings
4. Patient complaint response
5. Performance improvement measures

### **Patient Safety Committee and Reporting**

Patient safety is the responsibility of all employees and Medical Staff Members. The Patient Safety Program will be multi-faceted and that responsibility will be shared among several individuals, groups, and teams. Each performance improvement team is transdisciplinary in nature with representatives from the hospital and medical staff. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement team's are sent to the Quality Council, and reported to the Medical Executive Committee and the Governing Board.

The Patient Safety Committee is also transdisciplinary with representation from the following areas at a minimum: Clinical Departments, Pharmacy and Therapeutics

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Committee, Safety Committee, Quality/Risk Management and Infection Control.

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:
  - a. Risk and Safety Management
  - b. External Data Reports
  - c. Sentinel Event Alerts from the Joint Commission
  - d. Healthcare Reports
  - e. Regulatory Reports
  - f. Patient/Family members
2. Continually improve processes of care delivery based on data analysis.
3. Develop policies and procedures that result from process improvement activities.
4. Develop and approve Patient Safety Education for the medical and hospital staff
5. Conduct an annual risk assessment of patient safety issues/strategies from internal and external reports.

LifeCare Hospitals believe in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator.

The activities of the Patient Safety Program will be reported up to the Quality Council, the Medical Executive Committee and the Governing Board as outlined in the Performance Improvement Plan. Communication within the hospital and medical staff is the key to a successful patient safety program and will be encouraged.

Education and training is an important and effective tool in assuring that the Patient Safety Program is clearly understood, particularly error identification and reporting and the basic approaches to Patient Safety. Education and training on patient safety is included in new employee general and department orientation and reviewed annually. Additionally, education will be provided to patients and their families about their role in helping to facilitate the safe delivery of care.

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## Tahoe Pacific and Complex Care Hospital of Tenaya Patient Safety Program

### Purpose

Tahoe Pacific Hospital and Complex Care Hospital of Tenaya have developed a Patient Safety Program in conjunction with the Performance Improvement Plan and Program, the Risk Management Plan and Program, and the Hospital Scope of Services, in order to provide guidelines for implementation of an integrated patient safety program throughout the hospital and to comply with the requirements of the state of Nevada. It is the intent of the leadership of the hospitals to foster a safe and safety-conscious environment that promotes well being, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvement.

### Scope

Overall Patient Safety responsibilities include the following:

1. Improve the accuracy of patient identification. Through the use of 2 patient identifiers whenever performing procedures, administering medications or blood, taking blood samples or other specimens, or providing any other treatments or procedures.
2. Improve the effectiveness of communication among caregivers as contained in Handoff Communication Guidelines, Located under Best Practices in LifeCare Policies and Procedures
3. Improve the safety of using high-alert medications as contained in the LifeCare policy, Medication Safety: High Alert Medications
4. Ensure the identification, reporting, prevention and control of infections, including the role of proper hand hygiene as contained in the LifeCare policies, The Infection Control Plan and its addendums; Hand Hygiene, and other policies covering Blood and Body Fluid Exposure, Environmental Disinfection, Single Use of Drugs and Devices and Use of Isolation Precautions as contained in the Quality Management policy section.
5. Reduce patient falls and injuries from falls as contained in the LifeCare policy, Fall Prevention, through recommendations from the Falls Committee Performance Improvement Team and information about falls gathered from the Post Fall Assessment Form.
6. Improve the effectiveness of clinical alarms systems as contained in the LifeCare policy, Safety – Alarms- Clinical Equipment.
7. Identifying, preventing and correcting errors in the labeling, storing, prescription or administration of medications as contained in the LifeCare policies, Medication Storage, Dispensing – Labels, Dispensing Medications – General, and other policies contained in the Pharmacy section.
8. Ensuring the safe administration of prescription drugs, controlled substances, pharmaceutical services and other medications as contained in the LifeCare policy, Administration of Drugs, and other policies contained in the Pharmacy section.
9. The identification, investigation and reporting of Sentinel Events as contained in the LifeCare policy, Sentinel Events, and as prescribed by NRS 439.800 and following

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guidelines established by the Nevada State Health Department's Sentinel Event Registry. The Patient Safety Officer will also be responsible for the maintenance of Sentinel Event records.

10. Oversight of the maintenance of a sanitary environment by the facility through conduction of Environmental Rounds, Infection Control Rounds and day to day observations by supervisory and charge staff, as contained in the LifeCare policies, Safety Management Plan,; the Infection Control Plan, and other policies under Quality Management and Engineering.
11. Adoption and implementation of patient safety checklists to improve the health outcomes of patients in the medical facility and ensure the knowledge to provide care safely is applied consistently and correctly. These checklists may include best practices and competencies for treatments ordered by an independent licensed practitioner. Other examples may include the proper sequence for environmental cleaning and proper use of personal protective equipment. Also included are discharge checklists explaining discharge medications, aftercare instruction and other instruction needed at discharge. Current examples in use include:
  - a. Insertion of PICC lines.
  - b. Maintenance of foley catheters
  - c. Discharge checklist
  - d. Respiratory Treatment competencies

The primary focus of the Patient Safety Program is the patient; however the program also addresses the safety of visitors and staff from all clinical and organizational functions. The scope of the Patient Safety Program includes but is not limited to the occurrence of the following:

1. Adverse Drug Reactions
2. Falls
3. Restraints
4. Medication Errors
5. Hazardous Condition(s)
6. Near Misses
7. Sentinel Events

The role of the Patient Safety Program also crosses over into the safety of the environment of the hospital including oversight of the 7 Environment of Care Plans:

1. Safety Management Plan
2. Security Management Plan
3. Life Safety Management Plan
4. Medical Equipment Plan
5. Emergency Preparedness Plan
6. Hazardous Materials and Waste Management Plan,
7. Utilities – Utilities Management Plan

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Annual Reviews of each of the 7 plans are performed annually and reported to the Environment of Care Committee, the Medical Executive Committee and the Governing Board

### **Methodology**

The Patient Safety Program includes both proactive and responsive components.

Proactive: The proactive patient safety component emphasizes a proactive error reduction and avoidance program. The following will be reviewed to proactively identify patient safety issues:

1. Medical equipment and medication risk assessment activities
2. Sentinel event alert risk reduction activities
3. Performance improvement indicators and monitoring activities
4. Patient Satisfaction reports
5. Medical Record review reports
6. Staff orientation, evaluation, training, and education activities
7. Failure Mode and Effect analysis (FMEA) activities
8. Medical Staff Credentialing issues
9. Occurrence Report trending

Failure Mode Event Analysis (FMEA) will be conducted annually. The process to be studied each year will be determined in collaboration with medical staff, hospital leadership, and staff. Information from patient safety organizations such as the Institute for Medicine, Institute for Safe Medication Practices, and The Joint Commission will be disseminated to the appropriate departments and committees for action and implementation of recommendations.

Responsive: The hospital will utilize information gathered from risk assessments, sentinel event alerts, performance improvement measures, medical record review, and other data in order to track, trend, and respond to patient safety issues. Patient safety related issues will be ranked based on severity. The following will be reviewed for reactive patient safety issues.

1. Root Cause Analysis
2. Intensive Assessment and Analysis
3. Occurrence Report Findings
4. Patient Complaint Response
5. Performance Improvement Measures
6. Patient Satisfaction Survey Reports

### **Patient Safety Committee and Reporting**

Patient Safety is the responsibility of all employees and Medical Staff members. The Patient Safety Program will be multi-faceted and that responsibility will be shared among several individuals, groups, and teams. Each performance improvement team is

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transdisciplinary in nature with representatives from the hospital and medical staff. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement teams are sent to the Quality Council and reported to the Medical Executive Committee and the Governing Board.

In compliance with State of Nevada Regulations, the Patient Safety Committee will be comprised of:

- (1) The patient safety officer of the medical facility.
- (2) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.
- (3) One member of the executive or governing body of the medical facility.

The Patient Safety Committee is also transdisciplinary with representation from the following areas: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management, and the Hospital's Infection Control Preventionist.

The Patient Safety Committee functions include but are not limited to:

1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:
  - a. Risk and Safety Management
  - b. External Data Reports
  - c. Sentinel Event Alerts from The Joint Commission
  - d. Healthcare Reports
  - e. Regulatory Reports
  - f. Patient/Family Members
2. Continually improve processes of care delivery based on data analysis.
3. Develop policies and procedures that result from process improvement activities.
4. Develop and approve Patient Safety Education for the medical and hospital staff.
5. Conduct an annual risk assessment of patient safety issues/strategies from internal and external reports.

The Hospitals believe in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent

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mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator.

The activities of the Patient Safety Program and an annual review of the Patient Safety Plan, it's appropriate policies, forms, checklists and best practices will be reported to the Patient Safety Committee, the Medical Executive Committee, and the Governing Board as outlined in the Performance Improvement Plan and the LifeCare Reporting Calendar. Communication within the hospital and medical staff is the key to a successful patient safety program and will be encouraged.

Education and training is an important and effective tool in assuring that the Patient Safety Program is clearly understood, particularly error identification and reporting and the basic approaches to Patient Safety. Education and training on patient safety is included in new employee general and department orientation and reviewed annually. Additionally, education will be provided to patients and their families about their role in helping to facilitate the safe delivery of care.



# Document Information

## Document Title

Patient Safety Program

## Document Description

To establish the role of hospital leadership, hospital staff and medical staff in an intergraded patient safety program.

## Approval Information

**Approved On:** 07/01/2018

**Approved By:** Twila Loudder

**Approval Expires:** 07/01/2020

**Approval Type:** Manual Entry

**Document Location:** / Quality Management / Quality

**Keywords:** N/A

**Printed By:** Jacquelyn Niesen

**Standard References:** N/A

**Note:** This copy will expire in 24 hours



Current Status: Active

PolicyStat ID: 6494704



**Origination:** 06/2002  
**Effective:** 06/2019  
**Approved:** 06/2019  
**Last Revised:** 08/2018  
**Next Review:** 06/2020

**Owner:** Leslie Ayhens: QRM Director

**Policy Area:** Leadership

**References:** 439.800, 439.855, 439.860, 439.865, 439.870, 439.875, 439.877, 439.890, CMS CFR §482.21(e)(1), LD.03.01.01, NRS 439.835, TJC LD.04.04.05

**Applicability:** Northeastern Nevada Regional Hospital

## Patient Safety Plan

### SCOPE:

House Wide

### PURPOSE:

To build a system for providing safe patient care and for preventing adverse patient outcomes.

### DEFINITIONS:

**Adverse Event:** Harm to a patient as a result of medical care or harm that occurs in a healthcare setting. Although an adverse event often indicates that the care resulted in an undesirable clinical outcome and may involve medical errors, adverse events do not always involve errors, negligence, or poor quality of care and may not always be preventable.

**Error:** An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

**Facility-acquired Infection:** A localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

1. Surgical site infections;
2. Ventilator-associated pneumonia;
3. Central line-related bloodstream infections;
4. Urinary tract infections; and
5. Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

**Hazardous Condition:** Any set of circumstances (exclusive of the disease or condition for which the patient is being treated), which significantly increases the likelihood of a serious adverse outcome.

**Failure Mode and Effects Analysis (FMEA):** A systematic, proactive method for evaluating a process to identify where and how it might fail, and to assess the relative impact of different failures in order to identify the parts of the process that are most in need of change.

**Medical Error:** Any event (unanticipated outcome) within the control of a provider that results in harm and requires a new or modified practitioner order for management of the patient's medical care.

**"Near Miss":** Used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Near misses fall within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by The Joint Commission under its Sentinel Event Policy.

**"Sentinel Events":** Episodes of care that should never happen in any facility, at any time. Examples include patient abduction, wrong site procedure, and procedure on wrong patient.

**Root Cause Analysis:** A credible process for identifying the basic or causal factors that underlie variation in performance, including the risk of possible occurrence of a sentinel event.

**Hospital Acquired Conditions:** Conditions that result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis and could reasonably have been prevented through the application of evidence based guidelines. These include, but are not limited to:

1. Catheter-associated urinary tract infections
2. Central line-associated blood stream infection
3. Hospital acquired infections
4. Surgical site infections

**Patient Safety Officer (PSO):** The person who is designated as such by a medical facility pursuant to NRS 439.870. Northeastern Nevada Regional Hospital (NNRH) shall designate an officer or employee of the facility to serve as the PSO. The PSO will:

- Supervise reporting of sentinel events
- Serve on the patient safety committee
- Take such actions as he/she determines necessary to insure safety of patient as a result of sentinel event activity
- Report any action taken to Patient Safety Committee
- Work under the direction of the Director of Quality, Risk & Safety

## POLICY:

The Safety Plan at NNRH is implemented to provide a collaboratively planned, systematic, organization-wide approach to process design and performance measurement, assessment and improvement of patient safety. With a goal of delivering the safest and highest quality health care to the residents of the community, the plan is designed and organized to support the mission, vision and values of the hospital and LifePoint Healthcare Inc.

In formulating the plan, it is recognized that the implementation of an effective patient safety plan is dependent on a participative management approach, including all organization leaders, the Governing Board, senior management, the Patient Safety Committee, departmental management, and medical staff. We believe our plan provides our organization with the mechanisms to achieve patient safety that is expected by our customers and the community we serve.

Senior management is fully committed to the belief that improving patient safety is the most important challenge that we face in the healthcare industry and in our hospital. The purpose of the plan is to develop mechanisms to integrate and coordinate the activities of all of our healthcare staff so that patient safety is the foremost concern at every stage of every process that we conduct. Patient safety is to be the number one priority in the design of new processes, in the evaluation of existing processes and in the re-design of existing processes. The hospital-wide goal is to be proactive in preventing errors and complications.

To accomplish this goal, we are committed to comparing ourselves to national databases, searching for "best practices", studying designs of systems, and always searching for methods of strengthening our existing system designs by adding risk reduction strategies. Senior leaders regularly evaluate the culture of safety and quality using valid and reliable tools and prioritize and implement changes based on such evaluations. All individuals who work in the hospital are able to participate in safety and quality initiatives, either on an individual basis or a team approach. Staff, including the medical staff, is encouraged to discuss any areas of concern that impact patient safety and quality. Relevant literature concerning patient and staff safety is distributed throughout the hospital in the form of flyers, posters, newsletters and through staff meetings. Patients and their family members are encouraged to speak with the hospital staff concerning any safety and quality issues.

## PROCEDURE:

### INFECTION CONTROL

The patient safety plan works collaboratively with the infection prevention and control plan which is based on a yearly risk assessment carried out by the infection control nurse under the direction of the Infection Control committee. This plan will be developed by a nationally recognized infection control organization as approved by the State Board of Health which may include without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., The Centers for Disease Control and Prevention (CDC) of the United States Department of Health and Human Services, The World Health Organization, etc.

This facility-specific infection control plan must be developed and reviewed under the supervision of a certified infection preventionist, pursuant to NRS 439.865.

The infection control nurse will be responsible for the implementation of this plan under the approval of the Infection Control committee and Board of Directors.

In the absence of the infection control nurse, the house supervisor or director on call will be responsible for the control of infections at all times.

### REPORTING OF PATIENT SAFETY EVENTS

All employees have an affirmative duty to report any occurrence which is not consistent with the routine operation of the hospital and its staff, or the routine care of a particular patient or visitor, or any situation which has potential to cause harm to patients, visitors, or employees. This duty also applies to 'near miss' situations. *Willful failure to report such occurrences may subject the employee to corrective action up to and including termination.*

Patient related occurrences and other abnormal situations will be reported and tracked using an online electronic reporting database developed by **RL Solutions** according to the NNRH Occurrence Report Policy.

NNRH will follow all statutory, regulatory and licensing agency reporting guidelines and NNRH policies.

A. NRS 439.835 mandates that

- a. Within 24 hours after becoming aware of a sentinel event, an employee of NNRH will notify the PSO of the event.
- b. Within 13 days after receiving notification, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division using their occurrence reporting form.
- c. If the PSO personally discovers or becomes aware of a sentinel event in the absence of notification by another employee, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division within 14 days after becoming aware of the sentinel event using their occurrence form.

**National Quality Forum List of Serious Reportable Events:**

- A. Foreign object retained after surgery
- B. Wrong surgical procedure performed on a patient
- C. Surgery performed on the wrong patient
- D. Intraoperative or immediately postoperative death in an ASA Class I patient
- E. Death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
- F. Death or disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- G. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
- H. Infant discharged to the wrong person
  - I. Patient death or serious disability associated with patient elopement
- J. Suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility
- K. Death or serious disability associated with a medication error
- L. Death or serious disability associated with a hemolytic reaction to the administration of ABO/HLA incompatible blood or blood products
- M. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
- N. Stage 3 or 4 pressure ulcers not present on admission
- O. Death or serious disability due to spinal manipulative therapy
- P. Artificial insemination with the wrong donor sperm or wrong egg
- Q. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
- R. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- S. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- T. Patient death or serious disability associated with a fall while being cared for in a healthcare facility. This includes but is not limited to fractures, head injuries, and intracranial hemorrhage.

- U. Patient death or serious disability associated with the use of restraints or bed rails while being cared for in a healthcare facility
- V. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- W. Abduction of a patient of any age
- X. Sexual assault on a patient within or on the grounds of a healthcare facility
- Y. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a healthcare facility.

NRS439.837 mandates that the facility shall, upon reporting a sentinel event, conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event. A Root Cause Analysis (RCA) will be performed, with all staff involved with the sentinel event, with an ultimate goal of preventing a recurrence.

Once opportunities for improvement are identified, strategies for change can be developed using evidence based practice. Measures are used to determine the effectiveness of the improvement and ongoing feedback is provided to staff, the Patient Safety Committee and Quality Council.

#### DISCLOSURE OF EVENT TO PATIENT AND/OR FAMILY

When a sentinel event, hospital acquired condition, or an outcome that differs significantly from the anticipated outcome occurs, the patient, and when appropriate, the patient's family or the patient's designee shall be informed as soon as reasonably possible but within 7 days (NRS 439.855). The disclosure of facts of an event should occur after determination of the surrounding facts and after consultation with the Chief Executive Officer (CEO) or designee or Risk Management.

In most instances, disclosure should be handled by the attending physician who has responsibility for the overall care of the patient. The physician or his/her designee should communicate:

- Acknowledgement of the event
- Data known to date
- That a full analysis will take place
- What is currently taking place as a result of the event
- Additional data on an ongoing basis
- Measures taken to prevent recurrence
- Apologize that an event occurred.

#### PATIENT SAFETY COMMITTEE

The Patient Safety Committee is the interdisciplinary committee designated to manage the organization-wide patient safety program and shall be organized with strict adherence to NRS 439.875.

The Governing Board is responsible for the oversight of the Patient Safety Plan. The Patient Safety Committee functions under the guidance and with the oversight of the CEO and Quality Council, with the PSO, or designee, serving as Chairperson. The meetings, records, data gathered, and reports generated by the Patient Safety Committee are protected by the peer review privilege set forth by the Health Care Quality Improvement Act of 1986 (Title IV of Public Law 99-660, as amended, and other applicable Nevada Statutes).

The committee shall be composed of the following members and others as the committee may from time to

time add to accomplish specific goals and objectives within the authorized scope of activities outlined herein:

- A. Facility Patient Safety Officer
- B. Member of the Executive Team representing the Governing Board.
- C. Director, Quality, Risk & Safety
- D. Nursing representative
- E. Medical representative
- F. Member representing Pharmacy services
- G. Infection Prevention and Control Practitioner

At each monthly meeting, a representative from each of the medical, nursing and pharmaceutical staff, executive team or Governing Board, and the PSO or designee, should be in attendance.

Members of the Patient Safety Committee can be called ad-hoc to assist the PSO in analyzing possible sentinel events or adverse outcomes or assist with any other urgent patient safety matter.

The committee shall operate within the following scope of activities (NRS 439.870):

- Receive reports from the PSO
- Evaluate actions of the PSO in connection with all reports of sentinel events alleged to have occurred in the hospital
- Review and evaluate the quality of measures carried out by the hospital to improve the safety of patients who receive treatment at the hospital
- Review and evaluate the quality of measures carried out by the medical facility to prevent and control infection at NNRH.
- Make recommendations to the Governing Board to reduce the number and severity of sentinel events that occur at the hospital
- Adopt patient safety checklists and patient safety policies according to NRS 439.877 for use by:
  - All providers of health care who provide treatment to patients at the medical facility
  - Other personnel of the medical facility who provide treatment or assistance to patients
  - Employees of the medical facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility
  - Persons with who the medical facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at the facility
  - Patient safety checklists must follow best practice protocols to improve the health outcome of patients at NNRH according to NRS 439.877 and must include without limitation:
    - Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care
    - Checklist to ensure employees and contractors follow protocols to ensure that the room and environment of the patient is sanitary
    - Checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received discharge instructions regarding medication management
    - Instructions concerning aftercare and any other instructions concerning patient's care after discharge



- Checklists adopted by NNRH include:
  - Central Line Insertion (with prompt for practitioner order)
  - Universal Protocol and Surgical Site Fire Risk Assessment/Time Out
  - Safe Surgery Checklist
  - Discharge Instructions (prescription medication instructions, aftercare instructions, any other instructions related to discharge such as follow-up appointments)
  - Daily Room Cleaning (room and environment sanitation)
  - CDC Environmental Checklist for Monitoring Terminal Cleaning
  - Pre-Oxytocin Checklist (with prompt for practitioner order)
- In addition, the Patient Safety Committee will adopt and monitor compliance with our policy for the use of two patient identifiers, hand hygiene and any other patient safety checklist and policy adopted pursuant to this section. This may include active surveillance, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.
- The Patient Safety Committee shall monitor and document the effectiveness of the patient identification policy and at least annually, review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklist and patient safety policies that may be appropriate for adoption at NNRH.
- On or before July 1<sup>st</sup> of each year, the committee submits a report to the Director of the Legislative Council Bureau for transmittal to the Legislative Committee on Health Care. The report is to include information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph above outlining checklist review (NRS 439.800).
- At least once each calendar quarter, report to the Governing Board or Executive committee regarding:
  - The number of sentinel events that occurred at the hospital during the preceding calendar quarter; and
  - The number and severity of infections that occurred at NNHR during the preceding calendar quarter
  - Any recommendations to reduce the number and severity of sentinel events and infections that occur at the hospital.
- The proceeding and records of a patient safety committee are subject to the same privilege and protection from discovery as the proceeding and records described in NRS 49.265.

## REFERENCES:

TJC Standard LD.04.04.05 (2015): Patient Safety Program Components and Governing Body Report

TJC Standard LD.03.01.01 (2015): Patient Safety Culture Regular Evaluation (survey)

CMS CFR §482.21(e)(1): Patient Safety as a component of Performance Improvement Program

Nevada Revised Statutes §439.800 and any implementing Health Division and/or State Board of Health rules and regulations: Patient Safety Plan, Program, Officer and Committee; event reporting, investigation and action plan implementation; and an annual summary of events.

Nevada Revised Statutes §439.860 and any implementing agency rules and regulations pertaining to inadmissibility of report, document or other information compiled or disseminated pursuant to the provisions of §439.800 through §439.890, inclusive, in administrative or legal proceedings.



## Attachments

No Attachments

## Approval Signatures

| Approver                                      | Date    |
|-----------------------------------------------|---------|
| Alice Allen: CNO                              | 06/2019 |
| Becky Jones: Cardiovascular Services Director | 06/2019 |
| Pam Shotts: Quality Director                  | 06/2019 |

## Applicability

Northeastern Nevada Regional Hospital

COPY



**Northern Nevada Medical Center**

# **Risk Management/ Patient Safety Plan**

**Nevada Acute Care Division**

Revised 1/2020

## I. Overview

**Northern Nevada Medical Center** endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients. Patient safety is a cornerstone of quality care and is a leadership priority. **Northern Nevada Medical Center** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **Northern Nevada Medical Center** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **Northern Nevada Medical Center** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan (“Plan”) provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **Northern Nevada Medical Center**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the “Just Culture” concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **Northern Nevada Medical Center** policies. **Northern Nevada Medical Center** employees, contractors, vendors, and members of each facility’s medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

### GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.

- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

## II. Mission and Vision

**Northern Nevada Medical Center's** mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

**Northern Nevada Medical Center** recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

## III. ROLES AND RESPONSIBILITIES

### A. Risk Management/Patient Safety Officer

**Northern Nevada Medical Center** has a designated Risk Director/Manager responsible for patient safety risk identification and reduction for their respective facilities. The

designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) include:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

## **B. Infection Control Officer**

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee.
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the Patient Safety Plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a Certified Infection Preventionist.

### C. Patient Safety

**Northern Nevada Medical Center** has an established Patient Safety Council (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **Northern Nevada Medical Center** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to RiskConnect (STARS) and Midas) to maintain and manage PSWP.

#### I. Facility Patient Safety Committee

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully. Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

#### Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

#### Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

#### **Duties and Responsibilities:**

**Northern Nevada Medical Centers' PSC** is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the Patient Safety Checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.

- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt Patient Safety Checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, The Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

## **II. Patient Safety Advisories**

When an untoward event occurs at the facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, Safety Watch newsletters are distributed. These alerts detail the circumstances that lead to a negative outcome and the facility is charged with assessment and improvement of their own processes to prevent similar occurrences. In addition, Clinical Risk Alerts and Medication Safety Alerts are also formulated to apprise the facilities of a specific safety issue that needs to be assessed to prevent reoccurrence.

**Northern Nevada Medical Center** is required to address the Safety Watch newsletters, Clinical Risk Alerts and Medication Safety Alerts via their Patient Safety Committee and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

## **C. TERM Program**



The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

**Element I. Administration of the Risk Management Program:** The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

**Element II. Risk Identification:** Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

**Element III. Risk Education:** Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

**Element IV. Patient Safety Initiative:** Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC). The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

**Element V. Patient Safety Priority: Root Cause Analysis (RCA):** The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

**Element VI. Environment of Care; Safety and Security Programs:** The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

**Element VII. Claims and Litigation Management:** The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

**Element VIII. Patient Safety Organization (PSO):** Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

#### **D. MIDAS**

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

#### **E. Risk Connect (STARS)**

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by **Northern Nevada Medical Center** RM to the Governing Board of all claims activities.

#### **F. Event Notification Site**

The Event Notification Site or ENS, is a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and management. The ENS also provides an environment in which

stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

### **G. Root Cause Analysis (RCA)**

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that The Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

#### **RCA Responsibilities**

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



#### H. Patient Safety Checklists

By [NRS 439.865](#), the Patient Safety Plan must include the Patient Safety Checklists and Patient Safety Policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Patient Safety Checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

(For your reference— a checklist example is shown in **Appendix A.**)

## **I. Patient Safety Policies**

The Patient Safety Policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

## **J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)**

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out

patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

## K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired Risk Directors/Managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each Risk Director/Manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories
- Clinical Risk Alerts
- Medication Safety Alerts

## IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2020

- Surgical and Procedural Safety:
  - **Wrong Site Surgery (WSS).**
    - **Goal:** A 50% reduction in WSS events for 2020. Ultimately the goal is zero (0).
      - Monitor through Midas event reporting. Report monthly.
  - **Retained Procedural items (RPIs)**

- **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2020. Ultimately the goal for RPIs is 0.
    - Monitor through Midas event reporting. Report monthly.
    - Monitor through Universal Protocol. Report monthly.
- **CLABSI/CAUTI Initiative**
  - **Goal:** CLABSI and CAUTI will both be reduced to less than the National CMS mean Standardized Infection Ratio (SIR: CLABSI 0.783; CAUTI 0.857) in 2020.
  - Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly.
- **Safe Medication Use**
  - Opioid Analgesic Event Reduction Initiative
    - **Goal:** Decrease the number of preventable OIRD events by 10%.
    - Monitor through MIDAS reports, Cerner, ICD-10 Codes, and other intervention data. Report monthly.
- **Reduce Falls and Falls with Injury**
  - **Goal:** 10 % overall reduction in the number of falls in the facility by end of 2020.
  - Review of the progressive mobility (PM) documentation in the facility.
  - Correlation of PM documentation and fall incidents.
  - Review of the documentation of PM in the ICU with LOS and length of intubation.
  - Review of documentation of mobility and progression of mobility.
  - Monitor through MIDAS event reporting. Report quarterly.
- **Culture of Safety**
  - **Goal:** 100% of 2020 Patient Safety Plan Priorities will be implemented within the facility.
  - Monitor through MIDAS event reporting with monthly reporting to PSC.

## V. Monitoring and Accountability

### A. Evaluation of TERM Program

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined

during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

#### **B. Patient Safety Committee**

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed and detailed feedback is provided to coach the committee on their form and function.

#### **C. Dashboards**

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure.

### **VI. Evaluation/Review:**

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of "Near Miss" events
- The framework advances a "Just Culture" approach to patient safety
- Accountability is promoted when acts of "human error", "at risk", or "reckless behavior" are identified and corrected resulting in a reduction of potential/actual adverse outcomes.
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action
- Review of annualized and prior year's probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.



## VII. Confidentiality

All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities. The PSC annually reviews the effectiveness of the Safety Plan to ensure goals and objectives are appropriately focused on improving patient safety.

## VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the Governing Board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The Patient Safety Plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current Patient Safety Plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

### Appendix A: Checklist Example: Injuries from Falls and Immobility

| Process Change                                                      | In Place | Not Done | Will Adopt | Notes (Responsible & By When?) |
|---------------------------------------------------------------------|----------|----------|------------|--------------------------------|
| Conduct fall and injury risk assessment upon admission              |          |          |            |                                |
| Reassess risk daily and with changes in patient condition           |          |          |            |                                |
| Implement patient-specific intervention to prevent falls and injury |          |          |            |                                |

|                                                                                                                                                          |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| <b>Communicate risk across the team; use handoff forms, visual cues, huddles</b>                                                                         |  |  |  |  |
| <b>Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs)</b> |  |  |  |  |
| <b>Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds</b>               |  |  |  |  |
| <b>Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives</b>                                                                        |  |  |  |  |
| <b>Incorporate multidisciplinary input for falls</b>                                                                                                     |  |  |  |  |
| <b>Prevention from PT, OT, MD, RN and Phar.D.</b>                                                                                                        |  |  |  |  |
| <b>Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient</b>              |  |  |  |  |
| <b>Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls</b>                                      |  |  |  |  |

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

**PAM Rehabilitation Hospital of Centennial Hills**

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**QUALITY AND PATIENT SAFETY PLAN**

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DATE: 01/28/2020



This plan was created by the PAM Rehabilitation Hospital of Centennial Hills Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program  
PAM Rehabilitation Hospital of Centennial Hills  
6166 North Durango Drive  
Las Vegas, Nevada 89149**

**Prepared by Donna Rolshouse, R.N., C.P.H.Q.  
Director of Quality Management  
Patient Safety Officer**

*Quality and Patient Safety Plan*

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## Commitment to Patient Safety

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PAM Rehabilitation Hospital of Centennial Hills is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

### Mission, Vision, and Values

In support of our mission, vision, and values, PAM Rehabilitation Hospital of Centennial Hills Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

## Scope and Purpose

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The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in PAM Rehabilitation Hospital of Centennial Hills are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, PAM Rehabilitation Hospital of Centennial Hills has developed this

*Quality and Patient Safety Plan*

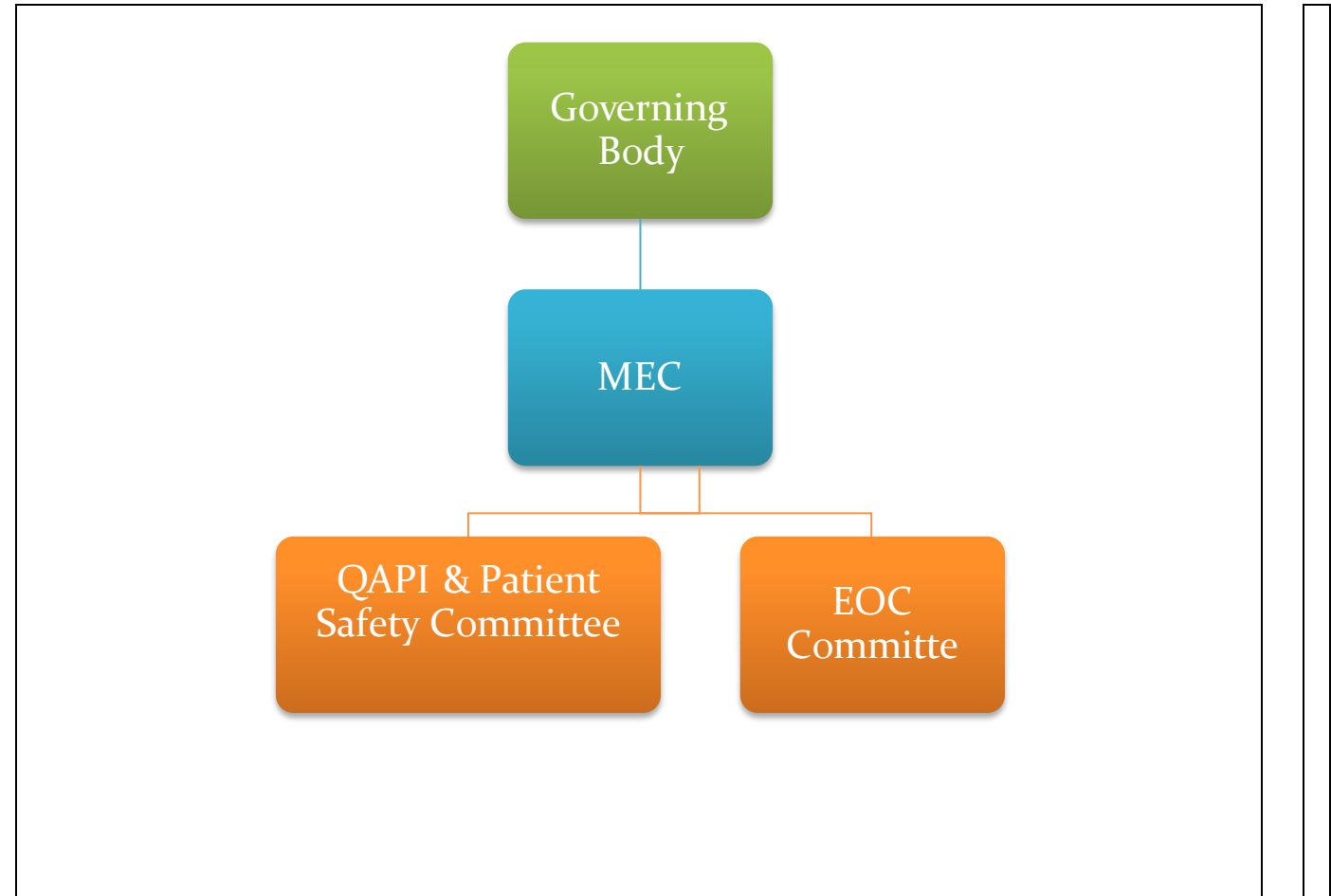
Patient Safety plan.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.



Quality and Patient Safety Plan

### Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below.

### Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\) \(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

### *Quality and Patient Safety Plan*



- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

#### Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

#### Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

#### Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

#### RCA team leader/facilitator Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

#### *Quality and Patient Safety Plan*

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plan.

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA effort

*Quality and Patient Safety Plan*

## Objectives and Goals of the Quality and Patient Safety Plan

| Objective                                                                     | Goals                | Plan                                                                                                                               | Planned Completion Date | Responsible Party                 |
|-------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------|
| Hand hygiene compliance                                                       | 95%                  | Observations and training, one on one coaching if indicated                                                                        | 12/31/2020              | Entire clinical team              |
| PPE Compliance                                                                | 95%                  | Observations and training, one on one coaching if indicated                                                                        | 12/31/2020              | Entire clinical team              |
| Patient Safety with scanning medications                                      | 100%                 | Scan all medications, all medications will have barcode and be scanned; education and monitoring                                   | 12/31/2020              | Pharmacy, Respiratory and Nursing |
| Keep falls at a minimum; no injuries                                          | Fall rate $\leq 7.0$ | Risk assessments; fall precautions implemented; monitoring; huddles for data collection                                            | 12/31/2020              | Nursing, therapy                  |
| Safe and successful discharges, keep LOA and acute transfers out to a minimum | Rate <10.0           | Hourly rounding; rapid responses if indicated and change in condition, post-acute huddles for information; post transfer analysis; | 12/31/2020              | Entire clinical team              |
| No hospital acquired pressure ulcers, =>stage 3                               | Zero                 | Daily and weekly skin assessments; education;                                                                                      | 12/31/2020              | Nursing                           |

*Quality and Patient Safety Plan*

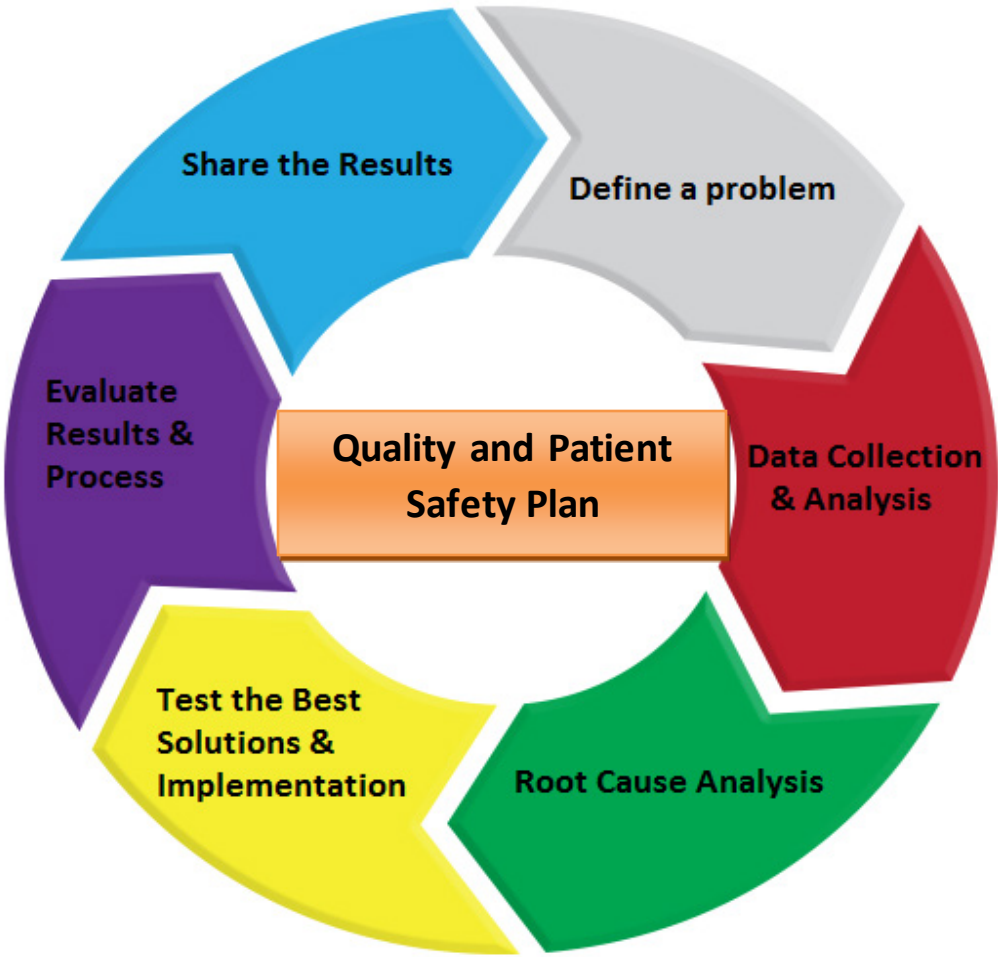
## Components and Methods

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Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

PAM Rehabilitation Hospital of Centennial Hills will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.

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**Root Cause Analysis**

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

**Root cause analysis and action plan framework table**, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

**5 Whys** technique will be used in PAMRehabilitation Hospital of Centennial Hills to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

*Quality and Patient Safety Plan*

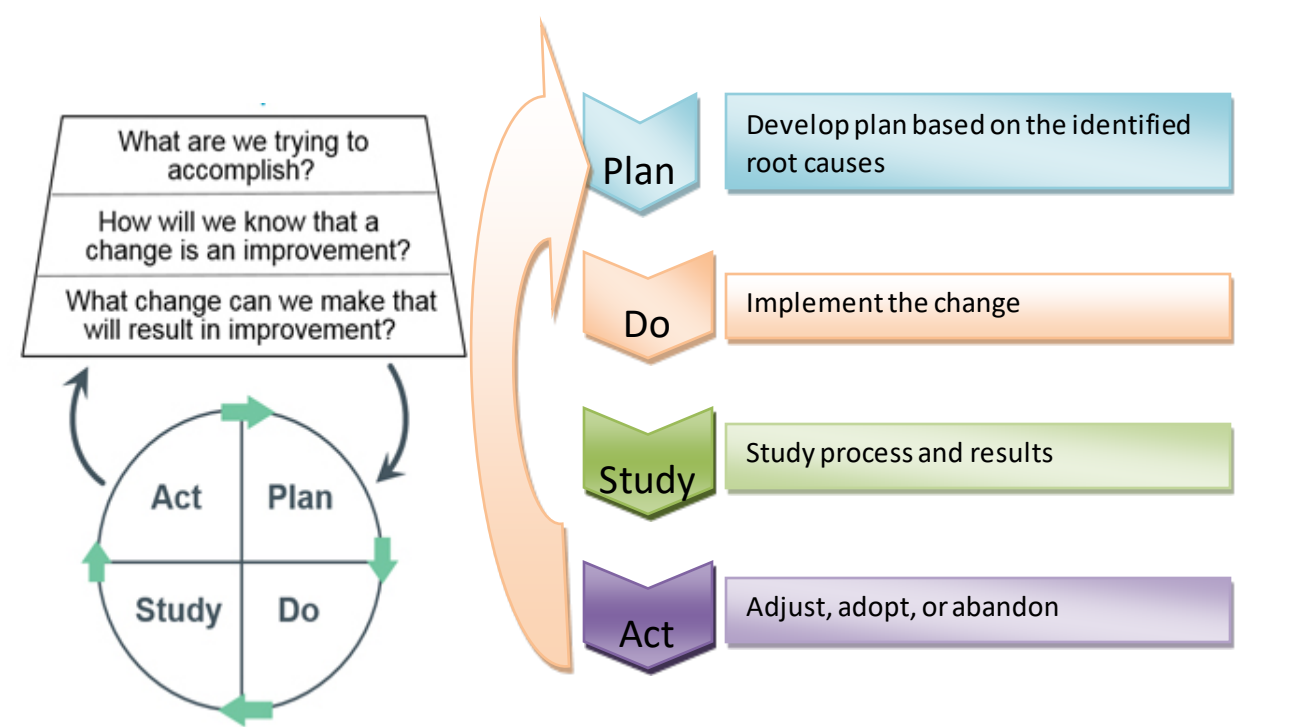
**Fishbone Diagram**

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

**Model for Improvement**

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.

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- What is the objective of the test?
- What are the steps for the test - who, what, when?
- How will you measure the impact of the test?
- What is your plan to collect the data needed?
- What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

### **Data Collection and Reporting**

Data should drive any quality and patient safety effort. PAM Rehabilitation Hospital of Centennial Hills is using from RMPRO, erehab, meridian, for tracking the sentinel events, healthcare infection data, and internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission

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Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

| Monthly                                                                                          | Quarterly                                                                                                                                                                                                                            | Annually                                                                                           |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| 1) Sentinel event monthly report<br><br>2) Severity of infection report<br><br>3) RCA assessment | 1) Sentinel event quarterly report<br><br>2) Severity of infection report<br><br>3) Review and evaluate the measure of improvement of patient safety<br><br>4) Review and evaluate the measurement to prevent and control infections | 1) Quality and Patient Safety Plan update<br><br>2) Checklists and Policies reviewing and revising |

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

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The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

*Quality and Patient Safety Plan*

- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference—a checklist example is shown in **Appendix E**.)

[http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix**

F.) <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

## Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

## Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools [http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/plan\\_do\\_study\\_act.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html)
- CQI 101 An Introduction to Continuous Quality Improvement: <https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 [https://www.jointcommission.org/sentinel\\_event.aspx](https://www.jointcommission.org/sentinel_event.aspx)
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety [http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>

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- Minutes of the Meeting of the Quality and Patient Safety Committee <http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

## Appendix A: Terms and Definitions

**Patient Safety:** The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.” [http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick\\_110.pdf](http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf)

### **Sentinel event** ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.
  2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:
    - (a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or
    - (b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.
  3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.
- (Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

### **Facility-Associated Infection:** ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and

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- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

**Medical facility** ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

**Near miss:** An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Mandatory reporting:** Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985; 254(6):796-800.)

**Risk:** Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

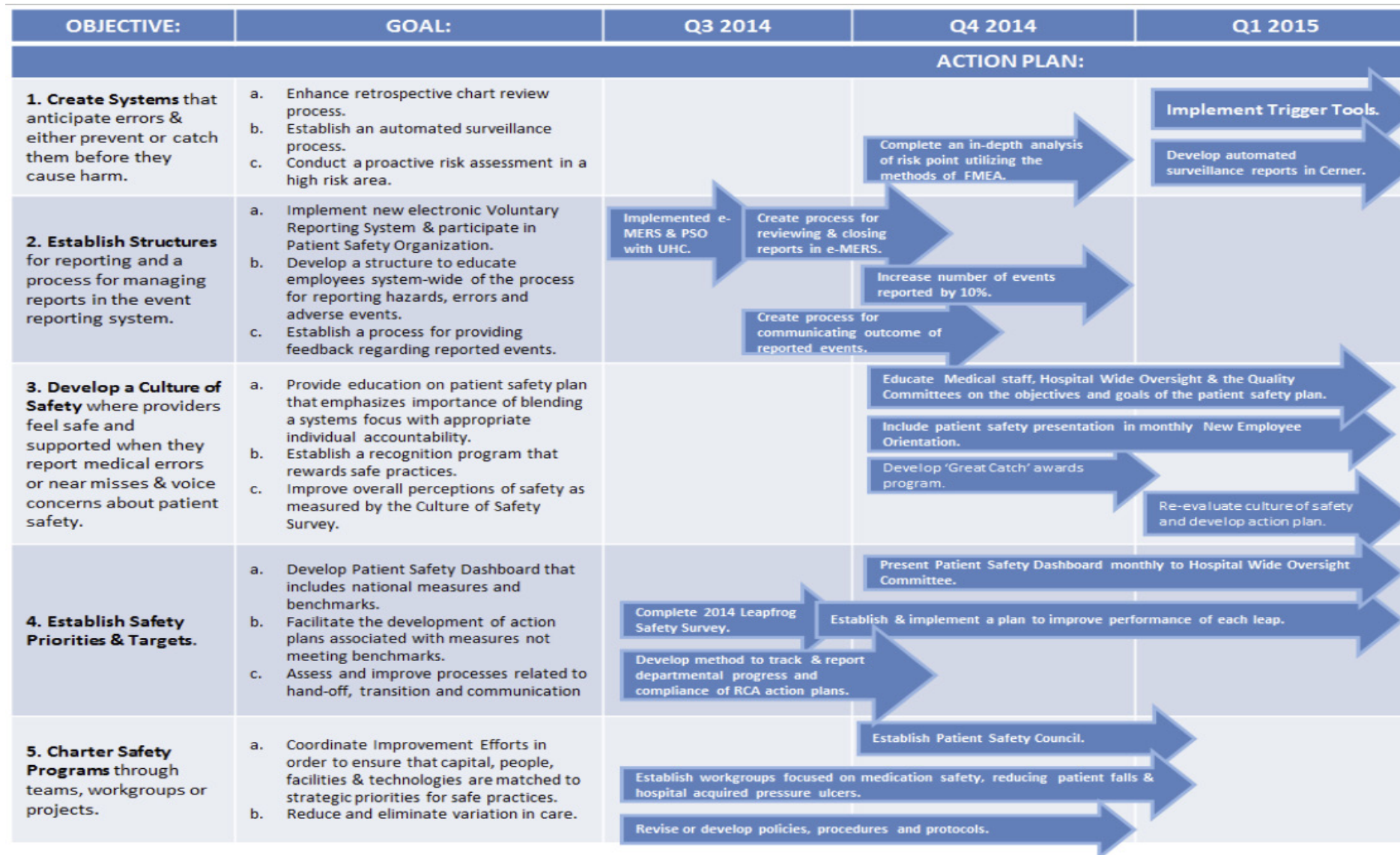
**Preventable event:** Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Catheter Associated Urinary Tract Infection (CAUTI):** A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at [http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN\\_Manual\\_PatientSafetyProtocol\\_CURRENT\\_b.pdf](http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf).)

**Central Line Associated Bloodstream Infections (CLABSI):** Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

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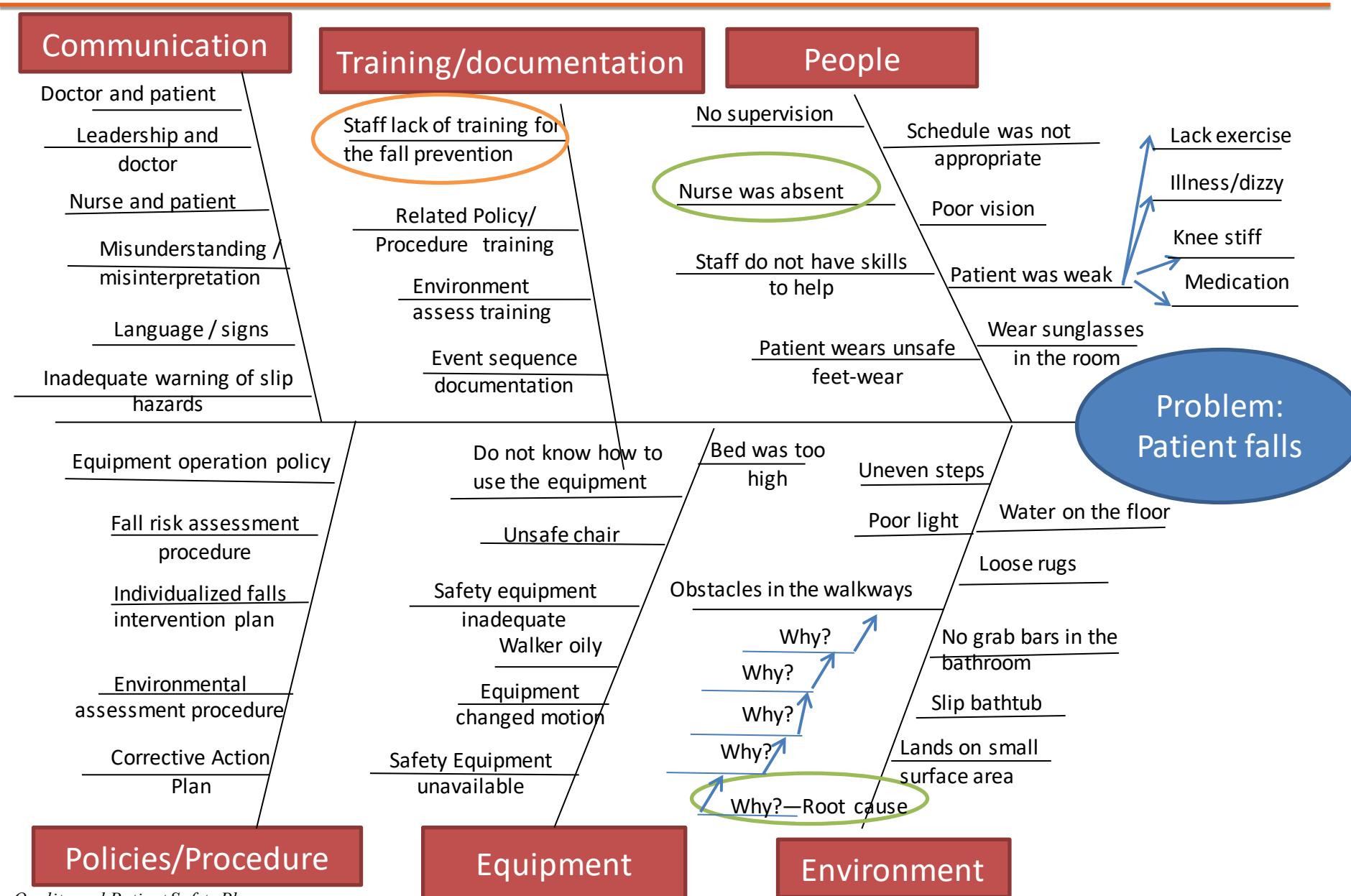
## Appendix B: Patient Safety Goals



Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

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## Appendix C: Fishbone Diagram



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Appendix D-1: PDSA Worksheet

PDSA Worksheet

|                                                                                 |  |        |  |
|---------------------------------------------------------------------------------|--|--------|--|
| Topic:                                                                          |  |        |  |
| Person Completing Worksheet:                                                    |  | Date:  |  |
| Telephone/ Email:                                                               |  | Cycle: |  |
| Patient Safety Committee Members                                                |  |        |  |
| CEOs/CFOs                                                                       |  |        |  |
| Patient Safety Officer                                                          |  |        |  |
| Infection Control Officer                                                       |  |        |  |
| Other Medical Staff                                                             |  |        |  |
| Other team members                                                              |  |        |  |
| <b>Aim:</b> (Describe the overall SMART goal that your team wishes to achieve.) |  |        |  |
|                                                                                 |  |        |  |
| <b>Plan:</b>                                                                    |  |        |  |
| 1. List the tasks needed to set up this test of change.                         |  |        |  |
|                                                                                 |  |        |  |
| 2. Predict what will happen when the test is carried out.                       |  |        |  |
|                                                                                 |  |        |  |

| 3. List the steps to develop the test-who, what, and when.                                                           |         |                                                                                                           |                 |
|----------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------------------------|-----------------|
| Steps                                                                                                                | By Whom | By When                                                                                                   | Desired Outcome |
|                                                                                                                      |         |                                                                                                           |                 |
|                                                                                                                      |         |                                                                                                           |                 |
|                                                                                                                      |         |                                                                                                           |                 |
|                                                                                                                      |         |                                                                                                           |                 |
|                                                                                                                      |         |                                                                                                           |                 |
|                                                                                                                      |         |                                                                                                           |                 |
|                                                                                                                      |         |                                                                                                           |                 |
|                                                                                                                      |         |                                                                                                           |                 |
| <b>Do:</b> (Describe what actually happened when you ran your test, including any problems and unexpected findings.) |         |                                                                                                           |                 |
|                                                                                                                      |         |                                                                                                           |                 |
| <b>Study:</b> (Describe what you learned and did you meet your measurement goal?)                                    |         |                                                                                                           |                 |
| Did you meet your measurement goal? Explain.                                                                         |         | <b>Summarize what was learned: success, failure, unintended consequences, etc.</b>                        |                 |
|                                                                                                                      |         |                                                                                                           |                 |
| <b>Act:</b> (Describe what you concluded from this cycle.)                                                           |         |                                                                                                           |                 |
| Based on what was learned, please indicate what action will be considered.                                           |         | <b>Describe what modifications to the plan will be made for the next cycle based on what you learned.</b> |                 |
| <input type="checkbox"/> Adapt: modify changes and repeat PDSA Cycle                                                 |         |                                                                                                           |                 |
| <input type="checkbox"/> Adopt: expanding changes throughout organization                                            |         |                                                                                                           |                 |
| <input type="checkbox"/> Abandon: change approach and repeat PDSA cycle                                              |         |                                                                                                           |                 |

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Appendix D-2: PDSA Monthly / Quarterly Progress Report

|                                                                                         |             |                      |  |
|-----------------------------------------------------------------------------------------|-------------|----------------------|--|
| Event:                                                                                  |             |                      |  |
| Person Complete Report:                                                                 |             | Date:                |  |
| Patient Safety Officer                                                                  |             | Contact Information: |  |
| Monthly / Quarterly Report                                                              |             |                      |  |
| Items                                                                                   | Description |                      |  |
| 1. What is your goal?                                                                   |             |                      |  |
| 2. Report on the PDSA cycle                                                             |             |                      |  |
| 3. What system and practices are working well? Explain.                                 |             |                      |  |
| 4. What areas for improvement did the data identify?                                    |             |                      |  |
| 5. What barriers or system issues have been encountered implementing action activities? |             |                      |  |
| 6. Action plans to address the barriers or system issues                                |             |                      |  |
| 7. Lesson learned                                                                       |             |                      |  |
| 8. Support needed                                                                       |             |                      |  |
| 9. Additional discussion                                                                |             |                      |  |
| Notes:                                                                                  |             |                      |  |

## Appendix E: Checklist Example: Injuries from Falls and Immobility

| Process Change                                                                                                                                    | In Place | Not Done | Will Adopt | Notes (Responsible & By When?) |
|---------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|------------|--------------------------------|
| Conduct fall and injury risk assessment upon admission                                                                                            | x        |          |            |                                |
| Reassess risk daily and with changes in patient condition                                                                                         | X        |          |            |                                |
| Implement patient-specific intervention to prevent falls and injury                                                                               | X        |          |            |                                |
| Communicate risk across the team; use handoff forms, visual cues, huddles                                                                         | X        |          |            |                                |
| Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs) | X        |          |            |                                |
| Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds               | X        |          |            |                                |
| Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives                                                                        | X        |          |            |                                |
| Incorporate multidisciplinary input for falls                                                                                                     | X        |          |            |                                |
| Prevention from PT, OT, MD, RN and PharmD                                                                                                         | X        |          |            |                                |
| Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient              | X        |          |            |                                |
| Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls                                      | X        |          |            |                                |

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

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Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

|                                                     |                                                                         |                                          |
|-----------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------|
| HOSPITAL POLICY AND INFORMATION MANUAL              |                                                                         |                                          |
| PERSONAL PROTECTIVE EQUIPMENT POLICY<br>Page 1 of 2 | Date Issued:<br>Date Last Revised:<br>Next Review Date:<br>Approved By: | 07/01 08/14<br>08/17<br>Policy Committee |

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by hospital
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQUIP5 - 1.5.1 and 1.5.2 Infection Control
- EQUIP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

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|                                                     |                                                                         |                                          |
|-----------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------|
| HOSPITAL POLICY AND INFORMATION MANUAL              |                                                                         |                                          |
| PERSONAL PROTECTIVE EQUIPMENT POLICY<br>Page 2 of 2 | Date Issued:<br>Date Last Revised:<br>Next Review Date:<br>Approved By: | 07/01 08/14<br>08/17<br>Policy Committee |

Implementation:

#### Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

#### Process

##### Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

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# PAM Specialty Hospital SPARKS

## 2020 Patient Safety Plan

### Purpose

PAM Specialty Hospital of Sparks has developed a Patient Safety Program in conjunction with the Performance Improvement Plan and Program, the Risk Management Plan and Program, and the Hospital Scope of Services, in order to provide guidelines for implementation of an integrated patient safety program throughout the hospital and to comply with the requirements of the State of Nevada. It is the intent of the leadership of the hospital to foster a safe and safety-conscious environment that promotes wellbeing, acknowledges and addresses risks, and encourages interdisciplinary safety and education focusing on process improvement.

### Scope

Overall Patient Safety responsibilities include the following:

- 1. Improve the accuracy of patient identification.** Improve the accuracy of patient identification. Through the use of two patient identifiers whenever performing procedures, administering medications or blood, taking blood samples or other specimens or providing treatment or procedures. Policies are in place to ensure compliance with the National Patient Safety Goals.
- 2. Improve the effectiveness of communication among caregivers** as contained in Handoff Communication Guidelines, Located under Best Practices in Post Acute Medical (PAM) Policies and Procedures Utilization of SBAR tools.
- 3. Improve the safety of using high-alert medications** as contained in the PAM policy, Medication Safety: High Alert Medications
- 4. Ensure the identification**, reporting, prevention and control of infections, including the role of proper hand hygiene as contained in the LifeCare policies, The Infection Control Plan and its addendums; Hand Hygiene, and other policies covering Blood and Body Fluid Exposure, Environmental Disinfection, **Single Use of Drugs and Devices** and Use of Isolation Precautions as contained in the Quality Management policy section.
- 5. Reduce patient falls and injuries from falls** as contained in the PAM Policy and Falls Prevention Program. Fall Preventions, through recommendations from the Falls Committee Performance Improvement Team and information about falls gathered from the Post Fall Assessment Forms. Investigation of all fall events is conducted.
- 6. Improve the effectiveness of clinical alarms systems** as contained in the PAM policy, Safety – Alarms-Clinical Equipment.

**7. Identifying, preventing and correcting errors in the labeling, storing, prescription or administration of medications** as contained in the PAM policies in conjunction with Cardinal Health, Medication Storage, Dispensing – Labels, Dispensing Medications – General, and other policies contained in the Pharmacy Program through Cardinal.

**8. Ensuring the safe administration of prescription drugs, controlled substances, pharmaceutical services and other medications** as contained in the Cardinal and PAM policy, Administration of Drugs, and other policies contained in the Pharmacy section.

**9. The identification, investigation and reporting of Sentinel Events** as contained in the PAM policy, Sentinel Events, and as prescribed by NRS 439.800 and following guidelines established by the Nevada State Health Department’s Sentinel Event Registry. The Patient Safety Officer, who is appointed annually, will also be responsible for the maintenance of Sentinel Event records.

**10. Oversight of the maintenance of a sanitary environment** by the facility through conduction of Environmental Rounds, Infection Control Rounds and day to day observations by supervisory and charge staff, as contained in the PAM policies, Safety Management Plan; the Infection Control Plan, and other policies under Quality Management and Engineering. **Ongoing collaboration with the EVS and Plant Operations of the Host Hospital (Northern Nevada Medical Center) is in place**

**11. Adoption and implementation of patient safety checklists to improve the health outcomes of patients in the medical facility** and ensure the knowledge to provide care safely is applied consistently and correctly. These checklists may include best practices and competencies for treatments ordered by an independent licensed practitioner. Other examples may include the proper sequence for environmental cleaning and proper use of personal protective equipment. Also included are discharge checklists explaining discharge medications, aftercare instruction and other instruction needed for safe discharge.

Current checklists in use include:

- a. Insertion of PICC lines.
- b. Maintenance of Foley catheters
- c. Discharge checklist
- d. Respiratory Treatment competencies

The primary focus of the Patient Safety Program is the patient; however the program also addresses the safety of visitors and staff from all clinical and organizational functions. The scope of the Patient Safety Program includes but is not limited to the occurrence of the following:

- 1. Adverse Drug Reactions
- 2. Falls
- 3. Restraints
- 4. Medication Errors
- 5. Hazardous Condition(s)

6. Near Misses
7. Sentinel Events

The role of the Patient Safety Program also crosses over into the safety of the environment of the hospital including oversight of the 7 Environment of Care Plans:

1. Safety Management Plan
2. Security Management Plan
3. Life Safety Management Plan /Fire Safety
4. Medical Equipment Plan
5. Emergency Preparedness Plan
6. Hazardous Materials and Waste Management Plan,
7. Utilities –Utilities Management Plan

Annual Reviews of each of the 7 plans are performed and reported to the Environment of Care Committee/Quality Council and Patient Safety Committee as well as the Medical Executive Committee and the Governing Board of the Hospital.

### **Methodology**

The Patient Safety Program includes both proactive and responsive components.

Proactive: The proactive patient safety component emphasizes a proactive error reduction and avoidance program. The following will be reviewed to proactively identify patient safety issues:

1. Medical equipment and medication risk assessment activities
2. Sentinel event alert risk reduction activities
3. Performance improvement indicators (department specific) and monitoring activities
4. Patient Satisfaction reports
5. Medical Record review reports
6. Staff orientation, evaluation, training, and education **activities to include a Culture of Patient Safety survey to be completed every 18 months.**
7. Failure Mode and Effect analysis (FMEA) activities
8. Medical Staff Credentialing issues
9. Occurrence Report trending

**Failure Mode Event Analysis (FMEA)** will be conducted at a minimum of every 18 months. The process to be studied each cycle will be determined in collaboration with medical staff, hospital leadership, and staff. Information from patient safety organizations such as the Institute for Medicine, Institute for Safe

Medication Practices, and The Joint Commission will be disseminated to the appropriate departments and committees for action and implementation of recommendations.

**Responsive:** The hospital will utilize information gathered from risk assessments, sentinel event alerts, performance improvement measures, medical record review, and other data in order to track, trend, and respond to patient safety issues. Patient safety related issues will be ranked based on severity. The following will be reviewed for reactive patient safety issues.

1. Root Cause Analysis
2. Intensive Assessment and Analysis/FMEA
3. Occurrence Report Findings
4. Patient Complaint/Grievance Response
5. Performance Improvement Measures
6. Patient Satisfaction Survey Reports
7. Serious Event Notifications /Sentinel Event Reporting
8. Culture of Patient Safety Survey
9. Hazard Vulnerability Analysis

### **Patient Safety Committee and Reporting**

Patient Safety is the responsibility of all employees and Medical Staff members. The Patient Safety Program will be multi-faceted and that responsibility will be shared among several individuals, groups, and teams. Each performance improvement team is multidisciplinary in nature with representatives from the hospital and medical staff. Imbedded in each performance improvement team are safety issues relevant to the team's focus. Reports from the performance improvement teams are sent to the Quality Council/Patient Safety Council and reported to the Medical Executive Committee and the Governing Board.

In compliance with State of Nevada Regulations, the Patient Safety Committee will be comprised of:

- (1) The patient safety officer (annually appointed) of the medical facility.
- (2) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility.
- (3) One member of the executive or governing body of the medical facility.

The Patient Safety Committee is also multidisciplinary with representation from the following areas: Clinical Departments, Pharmacy and Therapeutics Committee, Safety Committee, Quality/Risk Management, and the Hospital's Infection Control Preventionist.

The Patient Safety Committee functions include but are not limited to:



1. Review and evaluate internal and external patient safety data from the following sources for opportunities for improvement in the safety of patient care processes:

a. Risk and Safety Management

b. External Data Reports

c. Sentinel Event Alerts from the Joint Commission

d. Healthcare Reports

e. Regulatory Reports

f. Patient/Family Members to include Complaints and Grievances

2. Continually improve processes of care delivery based on data analysis.

3. Develop policies and procedures that result from process improvement activities **and corresponding checklists.**


4. Develop and approve Patient Safety Education for the medical and hospital staff.

5. Conduct an annual risk assessment of patient safety issues/strategies from internal and external reports.

The Hospital believes in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator/CEO.

The activities of the Patient Safety Program and an annual review of the Patient Safety Plan, appropriate policies, forms, checklists and best practices will be reported to the Patient Safety Committee, the Medical Executive Committee, and the Governing Board as outlined in the Performance Improvement Plan and the LifeCare Reporting Calendar. Communication within the hospital and medical staff is the key to a successful patient safety program and will be encouraged.

Education and training is an important and effective tool in assuring that the Patient Safety Program is clearly understood, particularly error identification and reporting and the basic approaches to Patient Safety. Education and training on patient safety is included in new employee general and department orientation and reviewed annually. Additionally, education will be provided to patients and their families about their role in helping to facilitate the safe delivery of care.

|                                                                                                                                     |  |                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
|  <b>Pershing General Hospital and Nursing Home</b> |  | <b>Policy Name:</b><br><b>Patient Safety Plan</b> |
| <b>Policy and Procedure</b>                                                                                                         |  |                                                   |
| <b>Department(s) Affected:</b> All                                                                                                  |  | <b>Policy Number:</b>                             |
| Approval Authority:                                                                                                                 |  | Approval Signature:                               |
| Approval Date:                                                                                                                      |  | Name:                                             |
| Effective Date:                                                                                                                     |  | Review Sign / Date:                               |
| Primary Responsibility:                                                                                                             |  | Review Sign / Date:                               |
| Review Sign / Date:                                                                                                                 |  | Review Sign / Date:                               |
| Revised Sign / Date: 12/28/2011                                                                                                     |  | Revised Sign / Date:                              |
| Replaces P&P Title:                                                                                                                 |  |                                                   |
| This P&P complies with the following regulation(s): NRS 439.865, NRS 439.830                                                        |  |                                                   |

## **PURPOSE:**

1. The purpose of the Organizational Patient Safety Plan at Pershing General Hospital is to improve patient safety and reduce risk to patients through an environment that encourages:
  - a. Recognition and acknowledgment of risks to patient safety and medical/health care errors;
  - b. The initiation of actions to reduce these risks;
  - c. The internal reporting of what has been found and the actions taken;
  - d. A focus on processes and systems;
  - e. Minimization of individual blame or retribution for involvement in a medical/health care error;
  - f. Organizational learning about medical/health care errors;
  - g. Support sharing knowledge to effect behavioral changes in itself and other healthcare organizations.
2. 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.
3. 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 Pershing General Hospital. The Patient Safety Plan, developed by the interdisciplinary Safety Committee and approved by the medical staff, Governing Board and administration, in accordance with NRS 439.865, outlines the components of the organizational Patient Safety Program.

## **PATIENT SAFETY PROGRAM:**

1. 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, maintain and improve patient safety. Patient safety occurrence information from aggregated data reports and individual

incident occurrence reports will be reviewed by the Risk Manager for presentation to the Safety/QA committee to prioritize organizational patient safety efforts..

- 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 facility and patient care functions of:
  - i. Patient Rights
  - ii. Assessment of Patients
  - iii. Care of Patients
  - iv. Patient/Family Education
  - v. Continuum of Care
  - vi. Management of Information
  - vii. Management of Human Resources
  - viii. Management of the Environment of Care
  - ix. Surveillance, Prevention and Control of Infection

## 2. Methodology:

- a. The Interdisciplinary Safety Committee is responsible for the oversight of the Patient Safety Program. The Safety Committee Chairperson will have administrative responsibility for the program, or the Safety Committee may assign this responsibility to another member of the committee (such as the Director of Risk/Quality Management).
- 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 Director of Risk/Quality Management, who will aggregate occurrence information and present a report to the Safety Committee. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety 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 sentinel event report information, occurrence reporting information from state and federal sources and current literature), the Safety Committee will select at least one high-risk safety process for proactive risk assessment annually. The proactive risk assessment will include:
  - i. 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;
  - ii. For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur;
  - iii. 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;
  - iv. Test and implement the redesigned process;
  - v. Identify and implement measures of the effectiveness of the redesigned process;

- vi. Implement a strategy for maintaining the effectiveness of the redesigned process over time.
- d. Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organization wide program.
- e. Upon identification of a medical/health care error, the patient care provider will immediately:
  - i. Perform necessary healthcare interventions to protect and support the patient's clinical condition.
  - ii. As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked. These items will be retained, not disposed of.
  - iii. Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
  - iv. Preserve any information related to the error (including physical information). 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.
  - v. Report the medical/health care error to the staff member's immediate supervisor.
  - vi. Submit the occurrence report to the Director of Risk/Quality Management per organizational policy.
- f. 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 Director of Risk/Quality Management per organizational policy
- g. Staff response to medical/health care errors is dependent upon the type of error identified:
  - i. 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 Director of Risk/Quality Management and notify their immediate supervisor.
  - ii. 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 Director of Risk/Quality Management per organizational policy.
  - 1. Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Services Department of the event.
  - iii. 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 Director of Risk/Quality Management per organizational policy. Staff will also notify the Pharmacy Services Department.
- iv. Transfusion Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician/ staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the Blood/Blood Component Transfusion Reaction Policy and Procedure.
  - v. 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 Director of Risk/Quality Management per organizational policy.
  - vi. 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.
  - vii. 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 Director of Risk/Quality Management.
- h. 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:
- i. Further remedial action activities necessary for identified occurrences
  - ii. Proactive occurrence reduction activities
  - iii. Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities
- i. 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
- i. 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 in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Services Department, Human Resources Department and/or his or her department supervisor.
  - ii. On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.

- j. 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.
  - k. 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 submitted through the Director of Risk/Quality Management for evidence of this information.
  - l. Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. The Safety Committee will request a report on a quarterly basis consisting of random record review verifying compliance with this educational process.
  - m. The Patient Safety Program includes consideration, at least annually, of data, which includes information regarding barriers to effective communication among caregivers. The Safety Committee will also request on a quarterly basis, a report identifying the effectiveness of the organization to provide accurate, timely, and complete verbal and written communication among caregivers and all others involved in the utilization of data.
  - 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. 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.
  - o. 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.
  - p. Patient safety reports from the Safety Committee will be submitted to the organizational Performance Improvement Committee, which exists as the oversight committee for the Safety Committee. A monthly data report and recordings of meeting minutes will be forwarded to the Performance Improvement Committee, with all information submitted held under the auspices of the Performance Improvement Committee.
  - q. A report will be forwarded to the Governing Board annually on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.
- 3. The patient Safety Committee will be composed of (NRS 439.875):
    - 1. Patient Safety Officer
    - 2. At least three providers of healthcare who treat patients at the medical facility including one member of the medical, nursing, and pharmaceutical staff
    - 3. One member of the executive or governing board of the medical facility
  - 4. The patient Safety Committee will meet monthly.
  - 5.

## PATIENT SAFETY PLAN

- I. The Patient Safety Committee of Quail Surgical and Pain Management Center has developed this Patient Safety Plan designed to ensure the health and safety of all patients treated at the Center. The Center Administrator and the Management Committee have designated the Operating Room Charge Nurse to serve as Patient Safety Officer. Activities involved in the Patient Safety Plan will be overseen and reported to the Patient Care Committee, the Clinical Review Committee and, ultimately, the Management Committee. The plan encompasses all aspects of patient care, including but not limited to:
  1. Building Security
    - a. Video surveillance to monitor access and the parking lot/grounds
    - b. Door security with coded building entry
    - c. Medical gases and vacuum pump lock-secured
  2. Medication Safety
    - a. Storage
    - b. Administration
    - c. Identification
    - d. Monitoring compliance
  3. Patient Transport
    - a. Gurneys, chairs, cribs, ambulating
    - b. Number of personnel
  4. Patient Positioning
    - a. Number of staff
    - b. Positioning devices
    - c. Recommended practices
  5. Infection Prevention
    - a. See Infection Control Plan
  6. Medical Equipment Safety
    - a. Preventative maintenance
    - b. Proper inservicing
    - c. Safety checks
    - d. Electrical equipment
    - e. Electrosurgical and Laser safety

- f. Radiology safety
  - g. Biomedical checks for new equipment and at scheduled intervals
- 7. Procedure Consents
  - a. Accuracy monitored
- 8. Emergency Management (Code, Fire, Transfer & Disaster Plans)
  - a. Medical emergency equipment, supplies, and medications available
  - b. Clinical alarm systems maintained
  - c. Staff competency maintained (education & drills)
  - d. Emergency power source maintained
  - e. Fire drills
  - f. See disaster plans
- 9. Patient Education
  - a. Pre-admissions instructions, testing, education
  - b. Post-operative discharge instructions
- 10. Protection of Patient Health Information
  - a. Privacy
  - b. IT information protection
  - c. "Red Flag" policy and staff training
- 11. Physical Plant Environment
  - a. Environmental controls monitored and maintained
  - b. Facility Safety Officer observations and reports
  - c. Consistent maintenance of the facility (floors, walls, etc)
- 12. Healthcare Personnel Competency
  - a. Orientation and training
  - b. Continuing education programs
  - c. Peer review, supervisory review, performance evaluations, competency reviews, credentialing criteria
- 13. Anesthesia Care
  - a. Equipment safety
  - b. Anesthesia gases
  - c. Competency/Peer review
- 14. Surgical Counts
  - a. Policy and procedure reviews
- 15. Sharps Handling
  - a. Safe sharps containers in patient care areas for disposal
  - b. Exposure Control Program



II. The **Patient Safety Officer**:

- a. Chairs the Patient Safety Committee
- b. Maintains documents and minutes of the Patient Safety Committee
- c. Supervises the reporting of Sentinel Events to the State and maintains documentation
- d. Assists in the investigation and analysis of any alleged sentinel event
- e. Coordinates and conducts a risk assessment for the identification of potential patient safety hazards at least annually
- f. Works with the Patient Safety Committee to determine resolutions to safety hazards identified in the risk assessment
- g. Reports all actions of the Patient Safety Officer to the Patient Safety Committee

III. The **Patient Safety Committee** is established to review, evaluate and recommend measures and actions designed to improve the safety of all patients receiving care at the Surgery Center. Committee members will also evaluate the actions and reports of the Patient Safety Officer regarding sentinel events and near-misses.

- a. Multidisciplinary membership to include:
  - 1. Patient Safety Officer
  - 2. Administrator
  - 3. Director of Nursing
  - 4. Medical Director
  - 5. PACU Charge Nurse
  - 6. RN Pharmaceutical coordinator/Contracted Pharmacist
  - 7. Facility Safety Officer
  - 8. Ad Hoc members as appropriate (Materials Manager, Sterile Processing Technician, Surgical Technologist, Radiology Technologist, Orderly)Members serve indefinitely.
- b. The committee generally meets monthly or in response to events or occurrences.
- c. The committee reports activities and makes recommendations to the Patient Care Committee, the Clinical Review Committee and the Management Committee

- IV. The patient safety plan and policies and procedures regarding patient safety are reviewed and approved annually by the Management Committee. These policies are based on state and local regulations and AORN's Recommended Practices. Policies are reviewed by staff upon hire and on a continual basis throughout the year.
- V. Patient safety is routinely included in Quality Improvement activities.
- VI. Surgery Center staff will initially review the Patient Safety Plan following approval of this plan by the Management Committee. All staff members will subsequently conduct an annual review of the plan. Signature sheets to indicate staff review will be maintained in the Inservice binder.
- VII. Medical staff and Allied Health personnel will be notified of the plan through written postings throughout the Center. Copies of the plan will be readily available for review.
- VIII. Compliance with the Patient Safety Plan will be monitored by Patient Safety Committee Members and reported to the Center Administration.

The Patient Safety Plan was reviewed and approved by the Management Committee on 1/20/20.

**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 Officer and Patient Safety Committee

**Owner:** Center

**Date last updated:** Revised 2/2020

**Purpose:** To ensure the ongoing safety of our patients.

**Patient Safety Officer:** The Manager of Quality Management, shall serve as the Patient Safety Officer. In the event the Manager of Quality Management is not available, the Director of Center Operations shall serve as the Patient Safety Officer. The duties of the Patient Safety Officer include, but are not limited to, the following:

1. Registration with the State of Nevada Health Division "Sentinel Events Registry Contact."
2. Serve on the Patient Safety Committee.
3. Supervise the reporting of all sentinel events alleged to have occurred within the Center to the Nevada State Health Division, pursuant to NRS 439.835.
  - a. The Safety Officer will report to the State within thirteen (13) days of receiving notification, becoming aware or discovering a sentinel event, using the electronic State Report Form.
4. Reviews, investigates and evaluates all sentinel events for cause, trend and prevention.
5. Takes any action necessary to ensure the safety of patients as the result of any review, investigation, and evaluation of all sentinel events.
6. Reports to the Patient Safety Committee all sentinel events and action taken.

**Patient Safety Committee:** The committee shall include the Patient Safety Officer, the RN Director of Center Operations, and the Medical Director/Administrator of the Center. The committee will meet monthly and report to the Center Board of Managers Meeting quarterly. The duties of the Safety Committee will include, but not be limited to:

1. Receive reports from the Patient Safety Officer of all sentinel events.
2. Evaluate the actions of the Patient Safety Officer in connection of all reports of sentinel events.
3. Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.
4. Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections in the facility.
5. 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.
6. At least once each calendar quarter, report to the governing body of the medical facility regarding:
  - a. The number of sentinel events that occurred at the medical facility during the preceding calendar quarter;
  - b. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter;
  - c. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

Approved Board of Managers REC/ SEC 10/11/11; CEC; Approved by Director of Center Ops, QM Manager, and Executive Director 2/14/19

*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.*

- d. Adopt patient safety checklists and patient safety policy; review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Refer to:

- Procedure, Adverse and Sentinel Event Policy
- Patient Safety Policy
- Infection Control Policy
- Nevada Sentinel Events Registry at [http://health.nv.gov/Sentinel\\_Events\\_Registry.htm](http://health.nv.gov/Sentinel_Events_Registry.htm).
- NRS 439.830 – 439.845; 439.875

Approved Board of Managers REC/ SEC 10/11/11; CEC; Approved by Director of Center Ops, QM Manager, and Executive Director 2/14/19

*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.*

## RENO ORTHOPAEDIC SURGERY CENTER, LLC

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**POLICY MANUAL**

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APPROVED BY: BOARD OF DIRECTORS

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**SECTION 13: SAFETY – SAFETY PROGRAM**

EFFECTIVE DATE: 10-12-07

REVISED: 2-28-12; 10-21-16; 3-29-19

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**TITLE:** Safety Program**SCOPE:** ROSC Staff**POLICY:**

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.

**PROCEDURE:**

1. A Safety Committee will be established to implement the safety and environmental control program of the facility.
2. The Safety Committee will include: Administrator, Safety Officer, Medical Director, Infection Control Officer, and Director of Surgical Services.
3. Management will appoint a Safety Officer.
4. The Safety Committee will meet monthly as part of the Medical Advisory Committee.
5. Meeting minutes will be taken and maintained.
6. Committee findings and recommendations are reported and submitted in writing to the Quality Management Improvement Committee and the Governing Board.
7. 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.
8. 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

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SECTION 13: SAFETY – SAFETY PROGRAM, continued

EFFECTIVE DATE: 10-12-07

REVISED: 2-28-12; 3-29-19

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**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.

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**POLICY MANUAL**

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**SECTION 13: SAFETY – ANESTHETIC WASTE GASES**

EFFECTIVE DATE: 10-12-07

REVISED: 3-26-19

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**TITLE:** Anesthetic Waste Gases**SCOPE:** ROSC Management**POLICY:**

To provide a safe environment for staff at the Reno Orthopaedic Surgery Center

**PROCEDURE:**

1. There will be a scavenger system connected to a separate vacuum from each anesthesia machine. The anesthesia practitioner makes sure that the hose is attached and inspected for leaks on a daily basis.
2. Biyearly inspections with written reports are obtained by an outside company qualified to test anesthesia waste gases. Management coordinates the inspection.
3. If any leaks are found on inspection, or the safe range is exceeded, the problem is immediately remedied before further use of the machine.

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**SECTION 13: SAFETY – CHECKLIST**

EFFECTIVE DATE: 9-20-11

REVISED: 2-28-12; 2-20-15; 3-26-19

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**TITLE:** Checklist**SCOPE:** ROSC Staff  
Physicians  
Contracted Vendors**POLICY:**

To provide protocols to improve the health outcomes of patients.

**PROCEDURE:**

ROSC Safety Committee adopts the following criteria from WHO Guidelines for Safe Surgery 2009, and meets these criteria, as a safety checklist for patient surgery:

Objective 1: The team will operate on the correct patient at the correct site

- Verification: Correct patient, site and procedure identified on the Pre-op, Anesthesia and Intra op document.
- Marking: Preoperatively the patient participates along with the surgeon that marks the site.
- Time Out: Intra-operatively by the team and documented on the intraoperative record.

Objective 2: The team will use methods known to prevent harm from administration of anesthetics, while protecting the patient from pain

- Pulse oximetry & capnography are supplied and performed by an anesthesiologist or directed by a physician.
- Circulation is monitored and documented in surgery and post op by anesthesia and nursing.
- Temperature is monitored and recorded pre-op, intra-op and post op.
- Consciousness is monitored and recorded pre-op, intra-op and post op.

Objective 3: The team will recognize and effectively prepare for life-threatening loss of airway or respiratory function

- Airway is assessed and documented by anesthesia on the anesthesia record.
- A difficult intubation cart is equipped and ready for use by anesthesia.
- Only credentialed anesthesiologists provide anesthesia at ROSC.



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**SECTION 13: SAFETY – CHECKLIST, continued****EFFECTIVE DATE: 9-20-11****REVISED: 2-28-12; 2-20-15; 3-29-19**

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Objective 4: The team will recognize and effectively prepare for risk of high blood loss:

- Large volume blood loss is not anticipated in a majority of the cases performed at ROSC
- The anesthesiologists communicate with the surgeon and evaluate each case appropriately.
- The Medical Director evaluates all questionable cases prior to surgery.
- IV's are established prior to each surgical case.
- Blood loss is recorded on the anesthesia record.
- Blood is not administered at ROSC.

Objective 5: The team will avoid inducing an allergic or adverse drug reaction for which the patient is known to be at significant risk:

- Credentialed anesthesiologists administer pharmacologic agents.
- Nursing administers medication under a physician order.
- Both physician and clinical staff are responsible for identifying the patient and the medication administered.
- A Patient Medication Reconciliation Record (signed by the patient), is obtained prior to surgery.
- Allergies and sensitivities are recorded on the front of the chart.
- Allergies and sensitivities are checked and recorded on the pre-op, intra-op, PACU and anesthesia records.
- Aseptic medication technique education is performed upon hire and annually.
- Medication drawn up and labeled is administered by the same person drawing and labeling the medication.
- National patient safety goals for the medication are followed by ROSC.

Objective 6: The team will consistently use methods known to minimize the risk for surgical site infection

- Prophylactic antibiotics are administered to all surgical cases prior to surgery by the anesthesiologist.
- Sterilization process involves the use of indicators used on every tray and peel pack. A Biological is run on each load.
- A surgical hand and forearm scrub for OR is done for 2-5 minutes.
- Sterile surgical attire is provided for each surgical case.

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**SECTION 13: SAFETY – CHECKLIST, continued**

EFFECTIVE DATE: 9-20-11

REVISED: 2-28-12; 2-20-15; 3-29-19

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Objective 7: The team will prevent inadvertent retention of instruments and sponges in surgical wounds

- Sponge and sharps counts are performed before and after each procedure and documented on the intra-op record.

Objective 8: The team will secure and accurately identify all surgical specimens

- All specimens have a patient label attached to the container.
- Pathology Specimen Request is complete and accompanies the patient specimen.

Objective 9: The team will effectively communicate and exchange critical information for the safe conduct of the operation.

- The team prepares for instruments, implants, intra-operative imaging, and pathology in advance of each case.
- Anesthesia issues are addressed by each anesthesiologist and surgeon prior to each case. When patient safety is in question, the case is cancelled.

Objective 10: Hospitals and public health systems will establish routine surveillance of surgical capacity, volume and results.

ROSC Management will report the following outcomes to the Nevada State Bureau of Health & Welfare Annually:

- Number of operating rooms –
- Number of procedure rooms –
- Number of surgical procedures performed
- Number of board certified Orthopaedic surgeons –
- Number of Anesthesiologists
- Day of surgery mortality rate
- Post-operative in-hospital mortality rate
- Surgical Site Infection Rate
- Surgical Complications

## RENO ORTHOPAEDIC SURGERY CENTER, LLC

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**SECTION 13: SAFETY – CHECKLIST, continued****EFFECTIVE DATE: 9-20-11****REVISED: 2-28-12; 2-20-15; 3-29-19**

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1. All treatment provided is ordered by the physician.
2. Any prescription given to the patient is filled at the patient's pharmacy of choice.  
Medication is taken as directed by the surgeon and pharmacist and documented on the discharge instruction sheet.
3. All after care and all other discharge instruction are given as ordered by the physician and documented on the discharge instruction sheet.
4. An environmental, staff and patient safety checklist is completed monthly the safety officer.
5. Orientation checklist.

## RENO ORTHOPAEDIC SURGERY CENTER, LLC

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**SECTION 13: SAFETY – COMPRESSED GAS HANDLING**

EFFECTIVE DATE: 10-12-07

REVISED: 3-29-19

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**TITLE:** Compressed Gas Handling**SCOPE:** ROSC Staff**POLICY:**

To provide guidelines for safe handling of compressed gas.

**PROCEDURE:****IDENTIFICATION:**

1. All gases are properly labeled with contents and whether they are flammable.
2. Never rely on the color of the tank for identification of the contents.

**STORAGE & HANDLING:**

1. Tanks of compressed gases are stored upright and chained to a support system to minimize falling over.
2. A safety cap is used during transport of H-cylinders.
3. Always use proper DISS or pin index safety system for the gas being used.
4. The gas storage area is kept cool and out of direct rays of the sun and away from heat pipes. It is well ventilated to prevent "pocketing" of fumes, and is fireproof with some means for cooling in the event of fire.
5. Regulators, fittings or gauges will never be lubricated or come in contact with oil or grease.
6. Never use leaking or defective tubing or equipment that is in need of repair.
7. When opening cylinder valve, always open with the face pointed away from any person.
8. Care should be taken to handle tanks safely. Seek assistance if tank is too heavy to handle alone. Never handle tank with greasy hands.

**DISPOSAL:**

1. All anesthesia gas scavenging systems are vented to the outside.
2. Empty cylinders and tanks are returned to the distributor.

## RENO ORTHOPAEDIC SURGERY CENTER, LLC

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**SECTION 13: SAFETY – ELECTRICAL SAFETY**

EFFECTIVE DATE: 10-12-07

REVISED: 3-29-19

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**TITLE:** Electrical Safety**SCOPE:** ROSC Staff**POLICY:**

To provide guidelines for general electrical safety

**PROCEDURE:**

1. All staff will observe for signs of electrical hazards. Equipment with frayed cords, exposed wire, or broken plugs will be taken out of use immediately. A sign that states "DO NOT USE" will be placed on equipment, and Management notified. Management will have the equipment repaired by the biomedical engineer.
2. Extension cords will be used only on an emergency basis.
3. All electrical devices being used in the operating room must have three-pin plugs and connect into three-hole receptacles.
4. Cheater plugs will never be used.
5. Keep fluids away from all electrical equipment.
6. Remove power plugs by grasping the plug; never pull on the cord.

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**SECTION 13: SAFETY – ELECTRICAL SAFETY CHECKS**

EFFECTIVE DATE: 10-12-07

REVISED: 3-29-19

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**TITLE:** Electrical Safety Checks**SCOPE:** Biomedical Engineering Contractor  
Management**POLICY:**

To assure that patients and employees are protected from electrical shock.

**PROCEDURE:**

All electrical appliances or equipment destined for patient care is to have an electrical safety check performed within 90 days of purchase with annual safety checks performed thereafter.

**PROCEDURE:**

1. Management or designee contacts the Biomedical Engineer to perform electrical safety inspections within 90 days of purchase.
2. The Biomedical Engineering Contractor inspects the equipment and places a label stating when the inspection took place and that the item is safe for use.
3. The Biomedical Engineering Contractor has a contract with ROSC to inspect new equipment and to perform annual inspections on all electrical equipment.
4. During routine inspections, if equipment is found to be defective or hazardous, Management is informed and a decision is made as to whether the item will be replaced or repaired.

## RENO ORTHOPAEDIC SURGERY CENTER, LLC

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**SECTION 13: SAFETY – GENERAL SAFETY IN THE WORKPLACE**

EFFECTIVE DATE: 10-12-07

REVISED: 3-29-19

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**TITLE:** General Safety in the Workplace**SCOPE:** ROSC Staff**POLICY:**

To identify general safety rules for all employees of ROSC.

**PROCEDURE:**

All employees of the Center will be familiar with the following the safety rules of the workplace. All employees will be responsible to observe and correct any hazards in the workplace.

1. Keep traffic areas clear of obstructions.
2. Pick up any foreign matter on floors and put in proper receptacles.
3. Wipe up spills immediately.
4. Use caution when opening doors. If no viewing window is present, open door slowly.
5. Be physically and mentally prepared for work.
6. Prevent spread of infectious disease by staying out of the workplace when ill.
7. Never engage in horseplay or practical jokes.
8. Walk, never run in the facility.
9. Heed all warning signs that caution a hazardous condition. (i.e., wet floor signs.)
10. Know the location of fire alarm pulls, extinguishers, and exits.
11. Be familiar with Emergency Codes.

## RENO ORTHOPAEDIC SURGERY CENTER, LLC

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**POLICY MANUAL**

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APPROVED BY: BOARD OF DIRECTORS

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**SECTION 13: SAFETY – INSTALLATION OF ALCOHOL BASED HAND SANITIZERS**

EFFECTIVE DATE: 8-30-10

REVISED: 3-29-19

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**TITLE:** Installation of Alcohol Based Hand Sanitizers**SCOPE:** Management**POLICY:**

To maintain a safe environment.

**PROCEDURE:**

ROSC will follow CfC 416.44 (b) Standard: Safety from Fire: “Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if—“

1. Use of alcohol-based hand sanitizer dispenser does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand sanitizer dispensers in health care facilities;
2. The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;
3. The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and
4. The dispensers are installed in accordance with the following provisions:
  - a. Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 feet (1.8m);
  - b. The maximum individual dispenser fluid capacity shall be: (1) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors. (2) 0.5 gallons (2.0 liters) for dispensers in suites of rooms;
  - c. The dispensers shall have a minimum horizontal spacing of 4 feet (1.2m) from each other;
  - d. Not more than an aggregate 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet;



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SECTION 13: SAFETY – INSTALLATION OF ALCOHOL BASED HAND RUBS, continued

EFFECTIVE DATE: 8-30-10

REVISED: 3-29-19

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- e. Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code;
- f. The dispensers shall not be installed over or directly adjacent to an ignition source; and
- g. In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments.

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**SECTION 13: SAFETY – LATEX ALLERGY**

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 3-29-19

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**TITLE:** Latex Allergy**SCOPE:** ROSC Staff**POLICY:**

To provide for a latex safe environment for patients with known latex allergies. To help prevent or minimize the risk of an allergic anaphylactic reaction secondary to exposure and sensitization to latex.

**PROCEDURE:**

1. When possible, schedule procedures as first case of the day, otherwise plan for a latex safe environment.
2. Notify all health care providers of potential or known latex-allergic patient before scheduled procedure.
3. Exchange latex-free products for all latex-containing items.
4. Notify surgeon and anesthesia care provider if no alternative latex free product is available.
5. Remove latex items from OR unless no non-latex alternative exists.
  - a. Remove boxes of latex gloves and replace with non-latex gloves (e.g., sterile, nonsterile).
  - b. Double check all supplies and equipment for latex and remove any latex-containing items.
6. Educate patient about latex-safe plan.

## RENO ORTHOPAEDIC SURGERY CENTER, LLC

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**SECTION 13: SAFETY – MEDICAL DEVICE PROBLEM & RECALL**

EFFECTIVE DATE: 10-12-07

REVISED: 3-29-19

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**TITLE:** Medical Device Problem & Recall**SCOPE:** ROSC Staff**PURPOSE:**

To establish a uniform policy to ensure that product problems and recall information is documented, disseminated and reported according to Federal guidelines.

**POLICY:**

The following steps will be performed by Management for all reported product alerts and product problems:

1. When a product alert is received, Management determines if the product is stocked in the surgery center.
2. If the product is in ROSC, appropriate action takes place according to instruction of the recall. This may include revision of usage instructions, removal of the product, or modification of the product.
3. Staff and physicians are notified by Management as to the proper action to follow.
4. If the product has been used on a patient, the manufacturer and the patient are notified.
5. If a product is used on a patient and malfunctions during use, the manufacturer must be notified and if any injury or potential injury has occurred, an incident report is filled out.
6. If a medical device has in all probability caused death, serious injury or illness of a patient, the FDA and the Nevada Department of Public Health and Environment must be notified. Management files the appropriate reports.
7. The report to the FDA must be made within ten days after the facility becomes aware the problem. The report includes the facility name and address, the device's name, serial number and model number; the manufacturer's name and address and a brief description of the event reported to the manufacturer.

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**SECTION 13: SAFETY – MEDICAL DEVICE PROBLEM & RECALL****EFFECTIVE DATE: 10-12-07****REVISED: 3-29-19**

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8. The “Occurrence Report – Equipment Malfunction or Misuse” form must be completed and submitted to the Nevada Department of Public Health and Environment (within one (1) business day of the occurrence. (See copy of form following this policy.)
9. A copy of the recall or problem and a copy of the reports to the FDA and applicable State reports are kept on file in the facility.

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**SECTION 13: SAFETY – PATIENT SAFETY PLAN**

EFFECTIVE DATE: 12-20-11

REVISED: 3-29-19

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**TITLE:** Patient Safety Plan**SCOPE:** ROSC Staff**POLICY:**

To provide ongoing safety and care for patients.

**PROCEDURE:**

1. Guidelines followed:
  - a. CDC Guideline for Hand Hygiene
  - b. ANSI/AAMI Comprehensive guide to steam sterilization and sterility assurance in health care facilities. Supported by CDC Guideline for Sterilization and Disinfection in Health Care Facilities.
  - c. CDC Environmental Infection Control in Healthcare Facilities
  - d. AORN Peri-Operative Standards and Recommended Practices
  - e. APIC Text of Infection Control and Epidemiology Guideline for Isolation Precautions
2. Additional Infection Control Policies – See Infection Control in Policy Manual for details
  - a. Aseptic Technique
  - b. Communicable Disease Reporting
  - c. Environmental Controls
  - d. Facility Sanitation
  - e. Housekeeping Logs
  - f. Infection and Complication Tracking
  - g. Laundry Guidelines
  - h. Operating Room Sanitation
  - i. Pest Control
  - j. Sterilizer Monitoring
  - k. Traffic Patterns
  - l. Wound Classification
  - m. Universal Precautions

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**SECTION 13: SAFETY – PATIENT SAFETY PLAN, continued****EFFECTIVE DATE: 12-20-11****REVISED: 3-29-19**

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### 3. Patient Selection and Screening

- a. Patients are pre-screened by the Surgeons and Medical Director for appropriateness for surgery.
- b. Patients with known infections and communicable disease are not a candidate for surgery at the facility.
- c. In the event that an infection or communicable disease is discovered at the facility the patient is isolated and appropriate discharge is determined by the physician. Reports are made to the appropriate agencies.

### 4. Patient Identification

- a. Identity is verified with two identifiers upon admission and prior to any procedure or treatment.

### 5. Timeout: Timeout is performed prior to procedure or surgery.

### 6. Discharge Teaching

- a. Written discharge instructions are reviewed with the patient and significant other prior to discharge.
- b. Patient medication is reconciled prior to discharge and a copy of their Medication Reconciliation Sheet is given to the patient.
- c. Patients are educated to report general as well as specific signs and symptoms related to the procedure.
- d. Patients are given a telephone number where they can reach a surgeon 24 hours a day.

### 7. Post Procedure Call

- a. Two attempts to call the patient post procedure are made within 72 hours following the procedure.

### 8. Pathology results

- a. Pathology results are sent directly to the surgeon's office.
- b. A designated ROSC nurse follows up on all pathology results and verifies that the surgeon received and reviewed the results.

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**SECTION 13: SAFETY – PATIENT SAFETY PLAN, continued****EFFECTIVE DATE: 12-20-11****REVISED: 3-29-19**

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**9. Pharmacy**

- a. ROSC has a consulting Pharmacist who reviews, updates and educates staff on policy and procedure related to Medications. (See Medication section of Policy and Procedure)
- b. The consulting Pharmacist performs a monthly audit of the Controlled Substances, DEA 222 forms, anesthesia narcotic reconciliation, patient charts.
- c. The Pharmacist produces a monthly report, recommendations and corrective actions are made to Management, Medical Director and the Medical Advisory Committee as deemed necessary.

**10. Quality Management and Improvement**

- a. Clinical data is collected on, however not limited to, the following: transfers to an acute facility, infections, patient falls, other patient complications, medication incidents and medical device issues.
- b. Quality Improvement Studies are performed to analyze issues for improvement.
- c. Data is reported to the Medical Advisory Committee and Board of Directors.

**11. Staff Training**

- a. Staff training is provided on hire, annually and as needed.

**12. Checklist and Logs**

- a. Checklists and logs cover, but are not limited to the following: safety, staff skills, cart checks, temperatures and expirations.

**13. Policies, Quality Management and Fire and Disaster Manual detail staff and patient safety.**

## RENO ORTHOPAEDIC SURGERY CENTER, LLC

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**POLICY MANUAL**

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**SECTION 13: SAFETY – RADIATION SAFETY**

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 10-21-16; 3-29-19

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**TITLE:** Radiation Safety**SCOPE:** Physicians  
Clinical Staff  
Radiology Technicians**POLICY:**

To provide guidelines that will limit exposure to radiation to personnel and patients in ROSC.

**PROCEDURE:**

1. All personnel in the operating room will wear a lead shield while x-rays are being taken. Personnel wearing lead aprons should always face the x-ray unit.
2. Lead shields will be used, when possible, to protect the patient's reproductive organs and thyroid during x-rays. The circulating nurse will document the type of protection used on the patient.
3. All reasonable means of reconciling an incorrect count should be implemented before using an x-ray to locate an unaccounted item.
4. Lead aprons will be laid flat or hung by the shoulders when not in use, to minimize cracking of shield.
5. The C-arm equipment will be inspected and calibrated annually by a state physicist, to ensure the equipment is working properly and meets safety regulations. Aprons and shields will be x-rayed bi-annually for any breaks in integrity. Any damaged aprons and shields will be disposed of.
6. All staff members working in the presence of fluoroscopy will wear dosimetry badges at the neck line. Dosimetry Badges will be maintained and monitored.
7. All staff assigned a dosimetry badge will be requested to report all other badge reports on an ongoing basis in order to help keep track of cumulative exposure.



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**SECTION 13: SAFETY – RADIATION SAFETY, continued****EFFECTIVE DATE: 10-12-07****REVISED: 8-30-10; 10-21-16; 3-29-19**

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8. The staff members assigned to operate the fluoroscopy equipment must carefully observe all radiation safety precautions and remind other medical personnel if radiation safety rules/practices are violated. Violations of radiation safety rules/practices must be documented and reported to Management.
9. Personnel are limited to receiving no more than the maximum permissible radiation dose limit per State or Federal guidelines.
10. Reproductive organ shielding shall be provided to all patients unless this area is essential to the clinical image.
11. All fertile female patients will be evaluated for the potential of pregnancy.
12. Thyroid shields will be worn by staff if they are in proximity to the patient.
13. The facility has an established Bio-Med agreement for the maintenance of all radiation equipment.
14. Any questions regarding radiological safety must be directed to Management who will contact the contracted X-ray technician or the state physicist.
15. Signs will be posted on OR and procedure room door when x-ray is in use.
16. Annual radiation safety competency will be completed by all staff.

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**SECTION 13: SAFETY – REFRIGERATOR MONITORING**

EFFECTIVE DATE: 10-12-07

REVISED: 3-29-19

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**TITLE:** Refrigerator Monitoring**SCOPE:** ROSC Staff**POLICY:**

To insure medications and food that require refrigeration are kept at proper temperature.

**PROCEDURE:**

1. The temperature in the refrigerator used for storage of patient food or medication must be kept between 36 degrees and 46 degrees Fahrenheit.
2. Medications and food is stored in separate refrigerators.
3. Refrigerators containing patient food or medications have a thermometer.
4. Staff checks the refrigerator temperature daily.
5. The temperature is recorded daily on the flow sheet. Flow sheet is filed with Management and kept for two years.
6. If there is a variance from the recommended temperature, the nurse notifies maintenance to have the refrigerator checked.

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**SECTION 13: SAFETY – REPORTING OF DEFECTIVE EQUIPMENT/INSTRUMENTS**

EFFECTIVE DATE: 10-12-07

REVISED: 3-29-19

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**TITLE:** Reporting of Defective Equipment/Instruments**SCOPE:** ROSC Staff**POLICY:**

To define the protocol to be used when an instrument or piece of equipment is not working properly. To assure that equipment and instruments that are defective are removed from the system until they are repaired.

**PROCEDURE:**

1. When an instrument or any piece of equipment in the Operating Room or Pre-op/PACU is found to be defective, the employee discovering the problem tags the item and removes it from service. Management is notified so action can be taken to have the device repaired or replaced.
2. The employee labels the item and describes the exact problem that was observed, to improve rapid repairs.
3. Management further investigates and has the item sent for repair as needed. Management communicates with the staff that the item has been sent out of the department for repair and if a loaner can be expected.
4. Upon return of the item, the device is checked by a staff member who is familiar with the device's performance or, if necessary, it is evaluated by the Biomedical Engineering Contractor prior to being returned to service.

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**SECTION 13: SAFETY – SAFE USE OF STERILIZER**

EFFECTIVE DATE: 10-12-07

REVISED: 3-29-19

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**TITLE:** Safe Use of Sterilizer**SCOPE:** OR Staff  
Sterile Processing**POLICY:**

To assure safe use of sterilizers and prevent injuries from occurring when sterilizers are used.

**PROCEDURE:**

1. Employees participate in an in-service on the use of the sterilizer. They demonstrate that they can safely operate the autoclaves, and are familiar with the manual operation of the autoclaves.
2. The chamber door is opened slowly and never opened until the pressure gauge reads zero. Never look directly at the autoclave when opening the door. Excess steam may have accumulated and be released when the door is opened.
3. When removing items from the autoclave, mitts, towels or forceps are used. Never reach in the autoclave with bare hands or arms.

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**SECTION 13: SAFETY – SAFETY PRECAUTIONS WHEN USING OXYGEN**

EFFECTIVE DATE: 10-12-07

REVISED: 3-29-19

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**TITLE:** Safety Precautions When Using Oxygen**SCOPE:** ROSC Staff**POLICY:**

To assure safe handling of oxygen in the facility.

**DISCUSSION:**

Oxygen is a non-flammable, non-explosive gas, however it readily supports combustion. Any material that will burn in air will ignite more readily in an oxygen-enriched atmosphere. The higher concentration of oxygen, the greater is the intensity of burning. When oxygen is administered, the following precautions must be taken to prevent explosions and fire.

**PROCEDURE:**

1. The facility is a “no smoking” facility. “No Smoking” signs are posted and visitors are reminded of this policy.
2. Any defect in the oxygen administration system such as a leak or a malfunctioning flow meter must be reported to Management who contacts the appropriate service for repair or replacement of the part.
3. Oxygen equipment must have an oxygen pressure interlock system and fail safe mechanism.
4. All electrical cords and equipment must be grounded.
5. Materials such as oil, grease, alcohol and other highly flammable substances must be kept away from oxygen and oxygen equipment.
6. Be sure there is no oil on hands when handling any oxygen administration equipment.

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**SECTION 13: SAFETY – SAFETY WHEN MOVING PATIENTS OR OBJECTS**

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 3-29-19

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**TITLE:** Safety When Moving Patients or Objects**SCOPE:** ROSC Staff**POLICY:**

To provide guidelines for moving patients and objects to avoid injury to staff.

**PROCEDURE:**

## 1. Lifting:

- a. Look over the object to be lifted; making sure it is not too heavy or clumsy to handle alone.
- b. Stand close to the object with feet apart for balance. Make sure footing is secure.
- c. Bend knees. Keep back as straight as possible.
- d. Get a good grip and keep the weight close to your body.
- e. Lift gradually. Straighten knees and stand. Use leg muscles. Avoid quick, jerky motions.
- f. When the weight is too heavy or the object is too bulky to lift safely, get help.

## 2. Pushing and pulling objects:

- a. Get a good grip on the object; hands inside handles.
- b. Keep back as straight as possible.
- c. Brace your feet for maximum leg power.
- d. Bend your knees to get the best use of your body weight.

## 3. Carrying:

- a. Keep the load close to your body.
- b. Make sure your vision is clear and the load does not obstruct your view.
- c. Do not change your grip while carrying the load.
- d. Always face the spot on which the load will rest.

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SECTION 13: SAFETY – SAFETY WHEN MOVING PATIENTS OR OBJECTS, continued

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 3-29-19

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4. Transferring:

- a. Lock bed, recliner or wheelchair
- b. Explain transfer steps
- c. Encourage independent movement from the individual
- d. Keep individual close to the body
- e. Follow steps for lifting
- f. Transfer to locked bed, recliner or wheelchair
- g. Secure
- h. individual

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**SECTION 13: SAFETY – USE OF SIDE RAILS**

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 3-29-19

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**TITLE:** Use of Side Rails**SCOPE:** All Staff**POLICY:**

To assure the safety of patients who have had sedation or anesthetic drugs.

**PROCEDURE:**

1. The side rails of stretchers are put in an upright position if the patient has been given a preoperative sedative.
2. All patients transported on a stretcher must have the side rails in an upright position.
3. When the procedure is complete and the anesthetized patient is moved to the stretcher, the side rails are put in an upright position and remain up until the patient is transferred to a recliner or discharged.



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**SECTION 13: SAFETY – SENTINEL EVENTS**

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 2-27-15; 3-29-19

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**TITLE:** Sentinel Event**SCOPE:** ROSC Staff**POLICY:**

To identify and report to appropriate health regulatory agencies events resulting in an unexpected outcome. A thorough investigation for root cause analysis, implementation of improvement to reduce risk, and monitoring of the effectiveness of process improvement will occur following any reportable event.

**DEFINITION:**

Per [NRS 439.830](#) defines a sentinel event as: an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function.

**PROCEDURE:**

Any event identified below is reported to the Department of Health and Human Services-Nevada Division of Public and Behavioral Health. All occurrences are reported by the next business day.

A written report using the format provided by the State is completed and returned within 5 days of the occurrence. Prevention is encouraged through safe practices by the healthcare team.

**REPORTABLE OCCURRENCES:**

As of October 1, 2013 reportable events to the state Sentinel Registry include:

**Surgical or Invasive Procedure Events**

- A.** Surgery or other invasive procedure performed on the wrong site
- B.** Surgery or other invasive procedure performed on the wrong patient
- C.** Wrong surgical or other invasive procedure performed on a patient
- D.** Unintended retention of a foreign object in a patient after surgery or other invasive procedure

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**SECTION 13: SAFETY – SENTINEL EVENTS, continued**

EFFECTIVE DATE: 10-12-07

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E. Intraoperative or immediately postoperative/post procedure death in an American Society of Anesthesiologists Class 1 patient.

**Product or Device Events**

- A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
- B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
- C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.

**Patient Protection Events**

- A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
- B. Patient death or serious injury associated with patient elopement (disappearance)
- C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a health care setting.

**Care Management Events**

- A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- B. Patient death or serious injury associated with unsafe administration of blood products
- C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
- D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
- E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- F. Any Stage 3, Stage 4, or 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.

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**SECTION 13: SAFETY – SENTINEL EVENTS, continued**

EFFECTIVE DATE: 10-12-07

REVISED: 8-30-10; 2-27-15; 3-29-19

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**Environmental Events**

- A.** Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
- B.** Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
- C.** Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- D.** Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

**Radiologic Events**

Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

**Potential Criminal Events**

- A.** Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- B.** Abduction of a patient/resident of any age
- C.** Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
- D.** Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.



# Quality, Patient Safety Plan 2019

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This plan was created and revised by the Renown Health's Quality and Patient Safety Committee (QPSC). Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes. In addition, the plan is intended to encourage recognition, reporting, and acknowledgment of risks to patients, visitors, and employees as well as reduce medical/healthcare errors and/or preventable events. In addition this plan serves to direct the assessment of those services furnished directly by the organization or through contracted service, to identify opportunities to improve quality of those services and to implement appropriate corrective or improvement activities following the Plan, Do, Study, Act or PDSA model.

## Quality and Patient Safety Plan

### Contents

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## Commitment to Quality and Patient Safety

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Renown Health is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving culture, systems, and processes.

### Mission, Vision, and Values

In support of our mission, vision, and values, Renown Health's Quality and Patient Safety program promotes:

- Collaboration of leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Honest, open communication to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and values for each patient, family member, employee, and other healthcare providers.
- Responsibility for safety related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible patient outcomes.
- Incorporation of evidence-based safety practice guidelines to deliver high quality healthcare.
- Education of staff, physicians, new learners, patients and their families to promote patient safety and continuous quality improvement.

## Scope and Purpose

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This Quality and Patient Safety Plan applies across the entire Renown Health Acute Care Division.

All staff and physicians in Renown Health Acute Care Division are required to fully support and participate in this plan, and devote their expertise to the quality, patient safety, service and healthcare performance improvement process.

The purpose of this plan is to address safety, quality and service related concerns, challenges and to proactively identify opportunities to better serve patients and their families.

The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need for analyzing and improving processes. The core principles of this plan include:

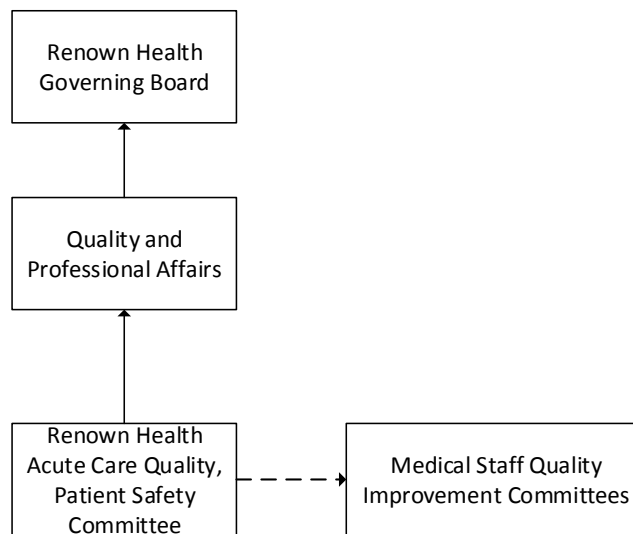
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- A customer-focused approach including patients, families, and visitors

- System-based thinking
- Utilization of trained, expert staff and physicians.

## Roles and Responsibilities

The Renown Health Acute Care Quality and Patient Safety Committee ensures that the Quality, Patient Safety Plan is promoted and executed successfully.

The Quality and Patient Safety Committee Organization



### Roles and Responsibilities

- In accordance with [NRS 439.875](#), the Renown Health Acute Care Quality and Patient Safety Committee is comprised of:
- The Renown Health Acute Care Infection Control Officer;
- The Renown Health Acute Care Patient Safety Officer;
- At least three providers of healthcare who treat patients, including at least one member of the medical, nursing and pharmaceutical staff;
- One member of the executive or governing body;
- A representative from Executive Leadership.

### Quality and Patient Safety Committee Responsibilities (based in part on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy through event review and analysis when applicable.



- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
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- Make recommendations to the executive or governing body of the organization to reduce the number and severity of sentinel events and infections.
- At least once each calendar quarter, report to the executive or governing body of the organization regarding:
  - (1) The number of sentinel events that occurred;
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  - (3) Any recommendations to reduce the number and severity of sentinel events and infections.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
- A meeting agenda and minutes noting follow-up tasks will be kept.

#### Patient Safety Officer Responsibilities (based on [NRS 439.870](#))

- Serve on the Renown Acute Care Quality and Patient Safety Committee.
- Supervise the reporting of all sentinel events alleged to have occurred, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred.
- Report to the QPSC directly or through his/her designee any action taken in accordance with the responsibilities above.

#### Infection Control Officer Responsibilities (based on in part on [NRS 439.873](#))

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- Report to the QPSC the number and severity of infections either directly or through his/her designee.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred.
- Carry out the provisions of the infection control program adopted pursuant in part to [NRS 439.865](#) and ensure compliance with the program.

#### Quality and Professional Affairs Committee of the Renown Health Board

- Provide vision and leadership that informs the safety processes, and develops and foster a safe learning and improving culture.
- Ensures the priorities of patient safety are aligned with the strategic priorities of the health system.

## Components and Methods

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The Renown Acute Care Quality and Patient Safety Committee uses data as a basis for recommendations for improvement.

Upon the identification of a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

### Root Cause Analysis

Renown Health Acute Care Division will use Root Cause Analysis (RCA) to determine the contributing factors and the underlying reasons for the deficiencies or failures involving sentinel events. Transformational Health Care principles and methods are incorporated into Renown’s RCA process.

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- Persons with whom the organization enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Renown Health Acute Care Quality and Patient Safety Committee reviews and approves annually patient safety checklists based on policy.

The Quality and Patient Safety Plan includes an infection control program that carries out the infection control policy. This program exists as individual and separate documents and consists of:

- The current guidelines appropriate for the scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
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## Approval of the Quality and Patient Safety Plan

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The Renown Health Quality and Patient Safety Plan is reviewed and updated annually and is approved by the Quality and Professional Affairs Committee of the Renown Health Board.

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# Quality, Patient Safety Plan 2019

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This plan was created and revised by the Renown Health's Quality and Patient Safety Committee (QPSC). Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes. In addition, the plan is intended to encourage recognition, reporting, and acknowledgment of risks to patients, visitors, and employees as well as reduce medical/healthcare errors and/or preventable events. In addition this plan serves to direct the assessment of those services furnished directly by the organization or through contracted service, to identify opportunities to improve quality of those services and to implement appropriate corrective or improvement activities following the Plan, Do, Study, Act or PDSA model.

## Quality and Patient Safety Plan

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## Commitment to Quality and Patient Safety

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Renown Health is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving culture, systems, and processes.

### Mission, Vision, and Values

In support of our mission, vision, and values, Renown Health's Quality and Patient Safety program promotes:

- Collaboration of leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
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- Preservation of dignity and values for each patient, family member, employee, and other healthcare providers.
- Responsibility for safety related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible patient outcomes.
- Incorporation of evidence-based safety practice guidelines to deliver high quality healthcare.
- Education of staff, physicians, new learners, patients and their families to promote patient safety and continuous quality improvement.

## Scope and Purpose

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This Quality and Patient Safety Plan applies across the entire Renown Health Acute Care Division.

All staff and physicians in Renown Health Acute Care Division are required to fully support and participate in this plan, and devote their expertise to the quality, patient safety, service and healthcare performance improvement process.

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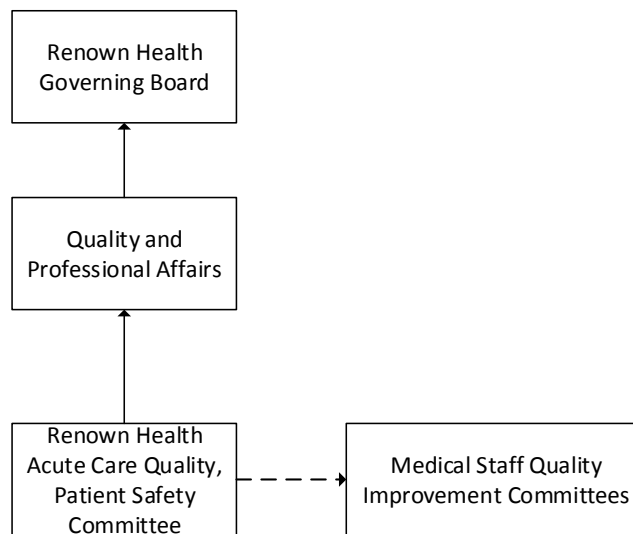
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Quality and Patient Safety Plan

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*Quality and Patient Safety Plan, 2019*

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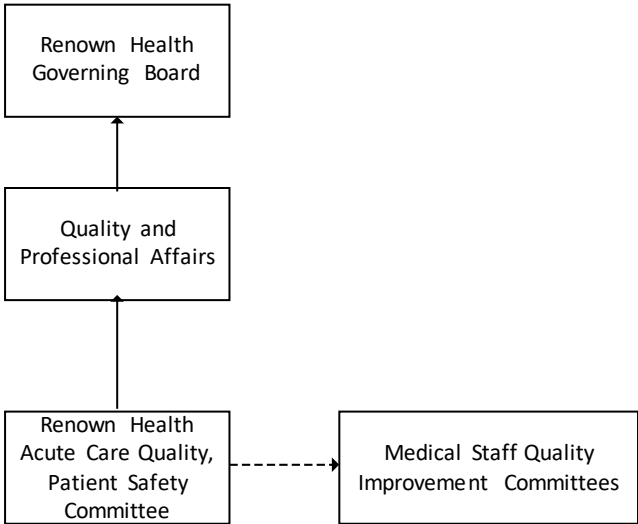
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*Quality and Patient Safety Plan, 2019*

## Sahara Surgery Center

# **SAFETY MANAGEMENT PROGRAM 2020**

### POLICY AND PROCEDURE

#### **Policy:**

It is the policy of the Sahara Surgery Center to provide a physical environment free of physical hazards for the patients, employees and visitors. In addition, monitor those activities that have the potential to minimize the possibility or risk associated with those physical hazards. The Governing Board has final oversight of the safety program/plan

#### **PURPOSE:**

The purpose of the safety management program is to establish, organize, implement, monitor, and evaluate an effective program designed to provide a physical environment free of hazards and to manage staff activities to reduce the risk of human injury. Safety is an ongoing process and each employee and medical staff provider should be constantly aware of providing a safe environment for themselves, patients and visitors.

#### **GOALS AND OBJECTIVES**

The objectives and goals of the safety management program are to reduce and eliminate unnecessary hazards within the facility by:

1. Identification of individuals who will be responsible for the overall coordination, direction, and monitoring of safety activities within the Sahara Surgery Center.
2. Establishing a procedure whereby any Sahara Surgery Center employee or medical staff member will be encouraged to identify and present problems, deficiencies, and ideas for review and analysis in an effort to improve overall safety at Sahara Surgery Center.
3. Assuring the various problems and opportunities to improve safety are objectively assessed and that performance indicators designed to achieve an optimum level of safety are monitored.
4. Assuring that the safety activities are properly documented to indicate findings, conclusion, actions, recommendations, and evaluation of the effectiveness of the action that was taken.
5. Providing for a method of communication that allows for effective collection and dissemination of information relating to safety activities.
6. Establishing and maintaining an ongoing mechanism for monitoring the resources necessary to ensure the safety of the patients, staff, visitors, building, grounds, and internal physical systems

#### **AUTHORITY AND RESPONSIBILITY**

The Governing Body shall maintain ultimate responsibility for the oversight and effectiveness of the safety management program and shall strive to assure a safe environment for patients, staff and visitors. The Governing Body, through Administration, Risk Manager, and managers

shall provide whatever administrative assistance that is reasonably necessary to support and facilitate the implementation of ongoing operation of this effort.

The Governing Body has appointed the Safety Officer. His/her role includes:

1. Oversight of the implementation and maintenance of safety practices at Sahara Surgery Center.
2. Proactive with ergonomics in the workplace - .Employee Health Nurse and Safety Officer work together to evaluate employee ergonomic needs and make appropriate referrals when indicated.
3. Integration of safety as part of Sahara Surgery Center wide Quality and Risk Plans.
4. Assures investigation and follow through of any unsafe practices identified.
5. Work with managers to ensure ongoing education of employees through staff inservice, emergency (mock) drills, online training, and new employee orientation.
6. Surveillance and audits to identify areas of opportunity.

Sahara Surgery Center, in conjunction with contracted Facilities Manager, will maintain a safe building and grounds.

1. Routine maintenance is provided by the contracted Facilities Manager.
2. Utilities and emergency backup systems are checked routinely.
3. Sahara Surgery Center should report any unsafe conditions in the building or grounds immediately to the management.
4. Sahara Surgery Center will conduct periodic safety rounds to check for potential hazardous risks. Risks are corrected as soon as possible.

### **SCOPE OF SAFETY MANAGEMENT PROGRAM**

The safety activities for the Center are a function of all employees, medical staff, the Medical Executive Committee (MEC), and Governing Body. The following delineates the scope of service of the safety management program.

1. All areas of the Center. This includes:
  - a) Clinical areas
  - b) Public access areas
  - c) Employee areas
  - d) Outside sidewalks and grounds
  - e) Mechanical equipment areas
2. Maintenance of a safe environment
3. Life Safety
4. Equipment management
5. Utilities management
6. Hazardous Materials management
7. Emergency preparedness
8. Security management
9. Training and Education
10. Quality Improvement activities

## **COMPONENTS OF THE PROGRAM/PLAN**

The safety management program shall contain the following components and related policies:

1. **Safety Management**, which includes:
  - a) General safety policies
  - b) Fall Risk assessment
  - c) Appointment of a Safety Officer
  - d) Staff Education and training
  - e) QI/Risk/Safety/Infection Control Committee
2. **Life Safety Management**, which includes:
  - a) Buildings
  - b) Grounds
  - c) Fire warning and safety systems
3. **Equipment Management**, which includes:
  - a) Patient care equipment
  - b) User errors/equipment failures
  - c) Product/equipment alerts/recall
  - d) Electrically powered equipment
4. **Utilities Management**, which includes:
  - a) Life support systems
  - b) Infection control systems
  - c) Communications systems
  - d) Equipment support systems
  - e) Utilities outage/failure
5. **Hazardous Materials**:
  - a) Selection
  - b) Training
  - c) Inventory
  - d) SDS
6. **Emergency preparedness**:
  - a) Management of disasters, internal and external
  - b) Involvement of the Center in community disaster (drills and actual)
7. **Security Management**
  - a) Variance reporting
  - b) Security risk assessment
8. **Radiation Management**
  - a. Dosimetry monitoring
  - b. Radiation audits
  - c. C-arm logs to assure < 20 individual exposure time

## **MONITORING AND EVALUATION**

There is ongoing monitoring of the safety program to ensure compliance with all regulatory agencies and Center policies. Results of the monitoring activities are reported to Administration, QI Committee, MEC and the Governing Body. The staff are informed through departmental meetings and staff in-services.

## **1. Data Resources Used for Monitoring**

- a) Quality/Risk Monitors
- b) Variance reports
- c) Outside regulating agencies reports ( AAAHC,TJC, QRS, CMS, State, Fire Marshall, OSHA etc)
- d) Preventive maintenance reports (from engineering and biomed)
- e) Surveillance rounds (IFC, Safety, Radiation etc.)
- f) Fire drill critiques
- g) Disaster drill critiques
- h) Claims data/Probable Claims Reports

## **2. Areas of Improvement**

Data information will be evaluated to determine if there are any problems or opportunities for improvements in the service. The source of the problem will be analyzed to determine if the problem occurred because of:

- a) Insufficient knowledge
- b) Problems in the system
- c) Poor performance due to lack of conformity to policy
- d) Other

## **3. Corrective Action**

Appropriate actions will be implemented to eliminate or alleviate the identified problems. Actions may be taken by the manager, Risk Manager, Administrator, or QI Committee. Actions may include, but are not limited to:

- a) Education/training
- b) Revision of policies and procedures or implementation of new policies
- c) Staffing adjustments
- d) Change in equipment, vendors, repair services, etc.
- e) Counseling/guidance

## **4. Follow-up and Evaluation**

- a) Follow-up and evaluation of the corrective actions will be done through the Quality Improvement/Risk Management Committee.
- c) Based on the evaluation by the Quality Improvement/Risk Management Committee, the need for further monitoring or additional corrective action will be determined.
- d) All evaluations of monitoring will be reflected in the Quality Improvement Committee, MEC, and Governing Body minutes.

## **5. Safety Monitoring and Evaluation Reporting**

Results of monitoring, evaluation, corrective actions and evaluation of same shall be communicated to:

- a) Center Quality Improvement/Risk Management Committee (Quarterly)
- b) Medical Executive Committee (Quarterly)
- c) Governing Body (Quarterly)
- d) Managers (monthly or as appropriate for dissemination to Center employees)

Findings and change in policies and processes are communicated to the staff through staff meetings or other desired method of communication.

## **POLICIES**

Sahara Surgery Center has policies and procedures that promote safety as a priority. These policies and procedures are developed in accordance with regulatory standards and current trends in healthcare. These policies include, but are not limited to...

1. Fall Risk Assessment
2. Product Recalls
3. Medication Administration and Control policies
4. USP 800 policies and guidelines
5. Exposure Control Plan
6. Sharps Prevention
7. Infection Control Plan
8. Equipment inventory and maintenance policies
9. Variance Reporting
10. Employee response grids to systems failure
11. Emergency Preparedness Plans- Bioterrorism, Weather, Evacuation, Fire Safety, Bomb Threats, etc.
12. Emergency Procedures- Respiratory Arrest, Malignant Hyperthermia. Child Abduction, Chemical Spills etc.
13. Procedures for Incapacitated and/or Impaired Healthcare provider

## **SAFETY MANAGEMENT PROGRAM APPRAISAL**

The program is reviewed at least annually or as indicated by other activities or survey findings.

**References:** AAAHC, JCAH, CMS, OSHA standards. HCA Life Safety program



# Saint Mary's Regional Medical Center:

## PATIENT SAFETY PLAN

DATE: 01/21/2019

VERSION: 01

TAMMY EVANS

RN,MSN,CPHRM



---

This plan was created and revised by Saint Mary's Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

All documents, materials and/or information prepared or created for the purpose of compliance with state law and/or peer review are confidential and deemed protected by the confidentiality provisions of any subsequent federal or state statute providing protection for related activities. Patient Safety files and their entire contents will be clearly marked —CONFIDENTIAL--and should not be copied or distributed without the advice of Legal Counsel.

## **Patient Safety Committee/Program**

*Patient Safety Plan*

**Saint Mary's Reginal Medical Center:**

235 West Sixth Street  
Reno, NV 89503  
(775)770-3000

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## Commitment to Patient Safety

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Saint Mary's Regional Medical Center is committed to providing quality healthcare to all patients. The Patient Safety Plan serves as a framework to establish and maintain a safe patient care environment. It expands the organization-wide support for risk management, performance improvement, information management, education, human resources and patient's rights by implementing patient safety standards, measuring and monitoring their effectiveness, and creating a "culture of safety" as part of the overall quality program.

### Mission, Vision, and Values

In support of our mission, vision, and values, Saint Mary's Patient Safety program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

## Scope and Purpose

---

The scope of this Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
  - Visitor safety
  - Employee safety
- 
- A. Saint Mary's recognizes that patients, staff and visitors have the right to a safe environment. Therefore, the organization commits to undertaking a proactive approach to the identification and mitigation of medical errors through the integration into and participation of all components of the hospital into the hospital wide program. This includes Performance Improvement, Risk, Infection Control and EOC programs.
  - B. The Patient Safety Plan promotes the use of internal and external knowledge and experience to identify, analyze, and prevent the occurrence of medical / healthcare errors and identify areas of opportunity to maintain and improve patient safety.
  - C. Patient safety information will be analyzed from aggregated data reports. All types of events can be addressed including "no harm", "near misses", and "sentinel events".

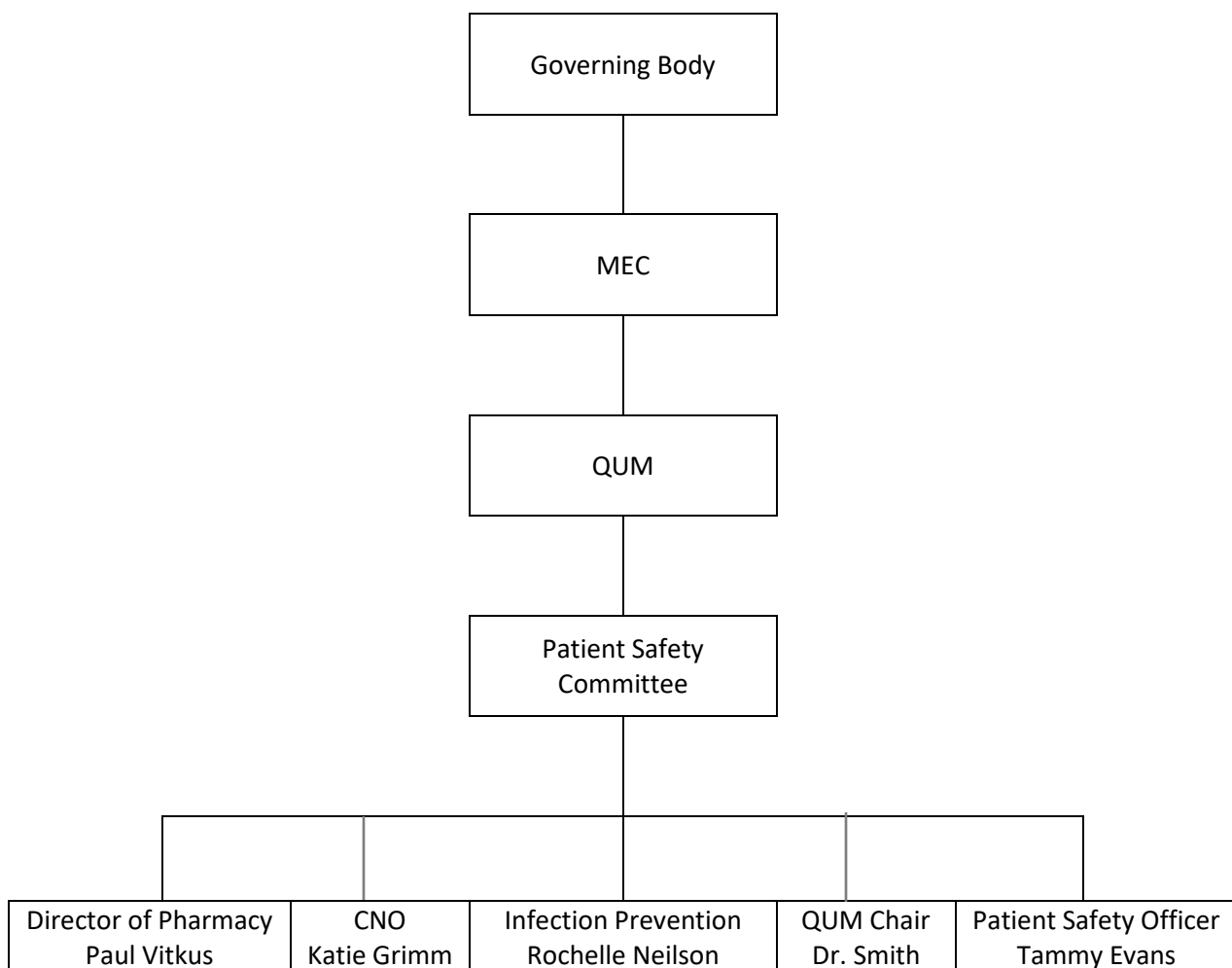
These reports will be reported to appropriate hospital and Medical Staff committees and to the Governing Board at regular intervals. The aggregate data will be used to prioritize organization-wide patient safety efforts.

- D. The organization also recognizes that despite our best efforts, errors can and will occur. Therefore, it is the intent of the organization to respond quickly, effectively, and appropriately when an error does occur.
- E. The organization also recognizes that the patient has the right to be informed of the results of treatment or procedures whenever those results differ significantly from anticipated results.

## Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



*Patient Safety Plan*

**Roles and Responsibilities**

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

The roles and responsibilities are defined below

**Patient Safety Committee Responsibilities** (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

**Patient Safety Officer Responsibilities** (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

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- Selects at least one high-risk patient safety process for proactive risk assessment (FMEA) at least every 12-18 months. Coordinates the process throughout this period.
- Presents Patient Safety reports to all departments.
- Develops, and recommends new policies and procedures for patient safety based on analysis of data from events, and other relevant information.
- Works in conjunction with the EOC Chair to prioritize risks, review and analyze data and performs risk analysis as needed to address the safety of the patient environment.
- Maintains the confidentiality and legal privilege, as appropriate, of all data and information.
- Facilitates patient safety orientation and in-service education programs.

#### Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

#### Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

A meeting agenda and minutes noting follow-up tasks will be kept.

## Objectives and Goals of the Patient Safety Plan

| Objective                                            | Goals                                                                                                                                                                                                | Plan                                                                                                                                                                                                                                                                                                                                                                                             | Planned Completion Date | Responsible Party |
|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------|
| Improve Hospital Handoffs & Transitions              | Use TC tools to standardize handoffs within and across hospital departments. Goal: Improve Hospital Handoffs & Transitions by 10% or more by the next Safety Attitude Survey. Current AHRQ value 16% | Saint Mary's will implement a performance improvement team with a bottoms-up approach to problem solving led by bedside employees. We will collaborate with physicians, nurses, and non-clinical staff to address both clinical and non-clinical processes associated with handoff communication. We will have a bias toward action implementing small tests of change utilizing the PDSA model. | July 1, 2019            | Alexandra Heidema |
| Reduce Misabeled Specimens                           | Use standardized data collection and process review to determine causation links                                                                                                                     | Saint Mary's will implement a mislabeled specimens committee to review data and report progress towards zero events to QUM                                                                                                                                                                                                                                                                       | July 1, 2018            | Sarah Jensen      |
| Improve response rate of AHRQ Safety Attitude Survey | Increase respondents by 30%                                                                                                                                                                          | Focus on patient care areas by removing non-clinical departments from denominator                                                                                                                                                                                                                                                                                                                | November 30, 2019       | Tammy Evans       |

## Components and Methods

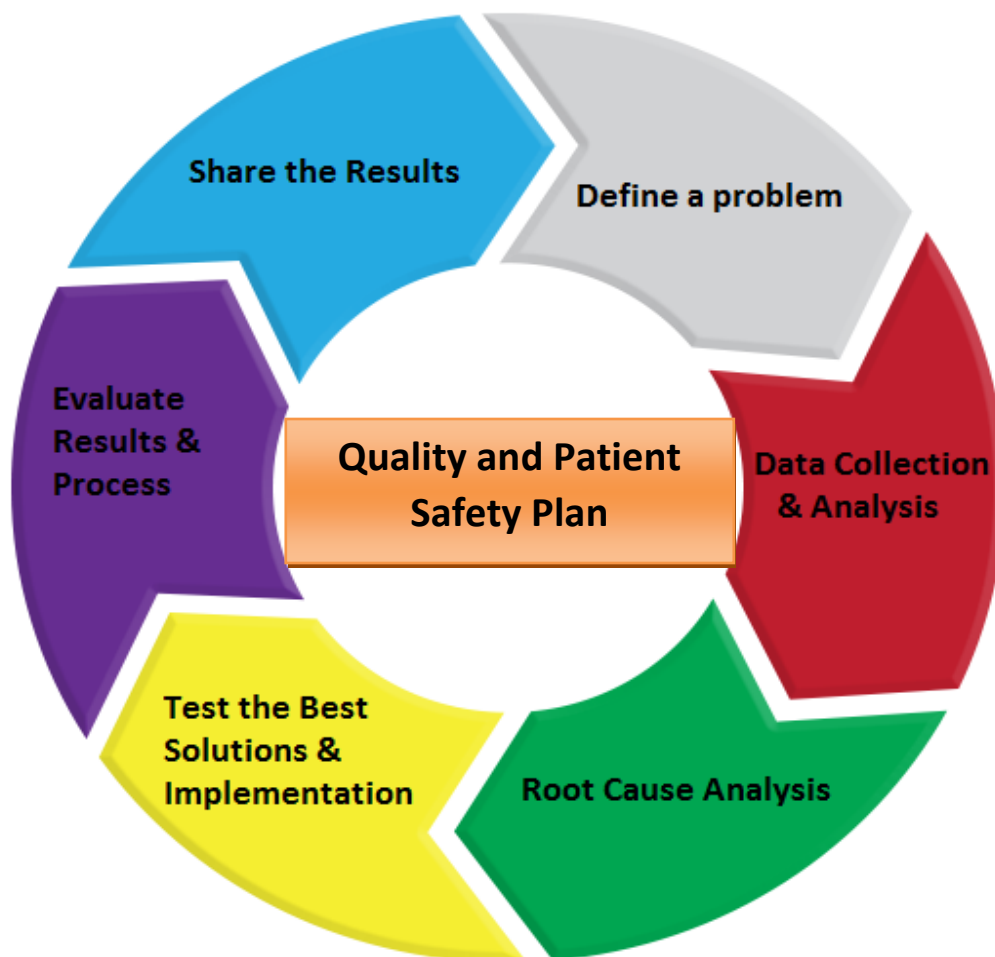
Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event."

Saint Mary's will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, which we will use to test the

*Patient Safety Plan*



changes.



### Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

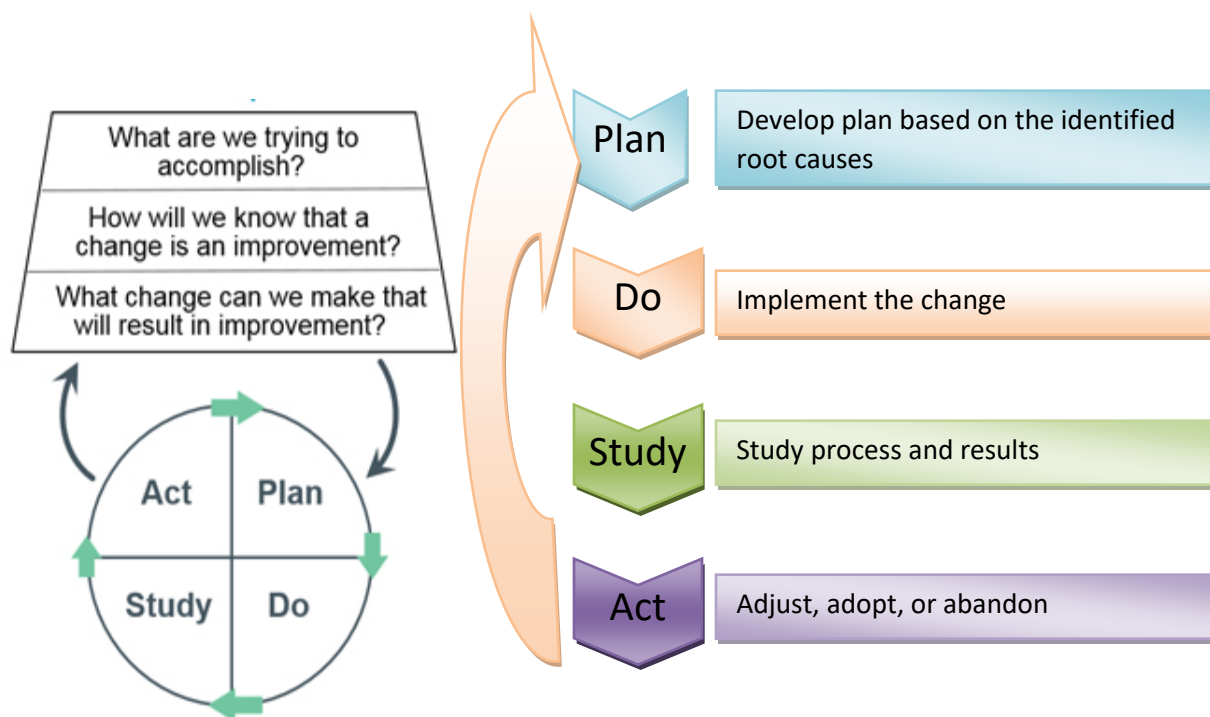
Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

**Root cause analysis and action plan framework table**, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

**5 Whys** technique will be used in Saint Mary's to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times.

## Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
  - What is the objective of the test?
  - What are the steps for the test - who, what, when?
  - How will you measure the impact of the test?
  - What is your plan to collect the data needed?
  - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?

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- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

## Data Collection and Reporting

In order to reduce the likelihood of patient incidents and negative outcomes, Saint Mary's shall track the frequency and type of medical errors and compile them in order to learn from and prevent future negative occurrences.

1. External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:
  - a. AHRQ: Agency for Healthcare Research & Quality
  - b. CDC: Centers for Disease Control and Prevention
  - c. CMS: Centers for Medicare & Medicaid Services
  - d. NQF: National Quality Forum
  - e. NHSN: National Healthcare Safety Network
  - f. TJC: The Joint Commission
2. Internal data sources:
  - a. Risk incident reports with database compilation
  - b. Adverse Drug Events and Adverse Drug Reactions
  - c. Data from patient complaints
  - d. Risk Management and Safety findings
  - e. Compliance findings
  - f. PI and special study findings
  - g. Infectious Disease information
  - h. Employee surveys
3. Risk Assessment (Failure Mode and Effect Analysis)
 

An assessment that examines a process in detail including sequencing of events; accesses actual and potential risk, failure, points of vulnerability; and through a logical process, priorities areas for improvement based on the actual or potential patient care impact (criticality).

#### 4. Data Analysis

Analysis of collected data will be undertaken to monitor and identify levels of performance, trends or patterns that vary significantly from expected outcomes and the need for possible change/improvement in systems or processes.

#### 5. Process Improvement

When undesirable outcomes are identified, the hospital shall involve the personnel, resources, disciplines, and department/services most directly involved with the process to reduce future risk.

### Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

| Monthly                                                                                          | Quarterly                                                                                                                                            | Annually                                                                                           |
|--------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| 1) Sentinel event monthly report<br><br>2) Severity of infection report<br><br>3) RCA assessment | 1) Sentinel event quarterly report<br><br>2) Severity of infection report<br><br>3) Review and evaluate the measure of improvement of patient safety | 1) Quality and Patient Safety Plan update<br><br>2) Checklists and Policies reviewing and revising |

### Assessment of the Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

### Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;

*Patient Safety Plan*

- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

*Patient Safety Plan*

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. Saint Mary's has a separate Infection Prevention Plan developed by our certified Infection Preventionist. This document is available upon request.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E**.)

[http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

## Approval of Patient Safety Plan

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According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

### Approvals

---

Director Risk Management

---

Date

---

Chief Nursing Officer / Administrator

---

Date

---

Chief Executive Officer

---

Date

---

Chairman, QUM Committee

---

Date

---

Chief of Staff

---

Date

---

Governing Board

---

Date

*Patient Safety Plan*

## Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools  
[http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/plan\\_do\\_study\\_act.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html)
- CQI 101 An Introduction to Continuous Quality Improvement:  
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2  
[https://www.jointcommission.org/sentinel\\_event.aspx](https://www.jointcommission.org/sentinel_event.aspx)
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety [http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee  
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>



## Appendix A: Terms and Definitions

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**Patient Safety:** The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”  
[http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick\\_110.pdf](http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf)

**Sentinel event** ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

**Facility-Associated Infection:** ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

**Medical facility** ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);

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- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

**Near miss:** An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Mandatory reporting:** Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

**Risk:** Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

**Preventable event:** Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Catheter Associated Urinary Tract Infection (CAUTI):** A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at [http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN\\_Manual\\_PatientSafetyProtocol\\_CUR\\_RENT\\_b.pdf](http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf).)

**Central Line Associated Bloodstream Infections (CLABSI):** Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

## Appendix B: Patient Safety Goals

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**Goal 1** - Improve the accuracy of patient identification.

**NPSG.01.01.01**

Use at least two patient identifiers when providing care, treatment, and services.

**NPSG.01.03.01**

Eliminate transfusion errors related to patient misidentification.

**Goal 2** - Improve the effectiveness of communication among caregivers.

**NPSG.02.03.01**

Report critical results of tests and diagnostic procedures on a timely basis.

**Goal 3** - Improve the safety of using medications.

**NPSG.03.04.01**

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups, and basins.

**NPSG.03.05.01**

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient's laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient's laboratory values for coagulation will remain within, or close to, normal values.

**NPSG.03.06.01**

Maintain and communicate accurate patient medication information.

**Goal 6** - Reduce the harm associated with clinical alarm systems.

**NPSG.06.01.01**

Improve the safety of clinical alarm systems.

**Goal 7** - Reduce the risk of health care-associated infections.

**NPSG.07.01.01**

Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

**NPSG.07.03.01**

Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals.

Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.

**NPSG.07.04.01**

Implement evidence-based practices to prevent central line-associated bloodstream infections.

Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

**NPSG.07.05.01**

Implement evidence-based practices for preventing surgical site infections.

**NPSG.07.06.01**

Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

Note: This NPSG is not applicable to pediatric populations. Research resulting in evidence-based practices was conducted with adults, and there is no consensus that these practices apply to children.

**Goal 15** -The hospital identifies safety risks inherent in its patient population.

**NPSG.15.01.01**

Identify patient at risk for suicide.

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
2. Address the patient's immediate safety needs and most appropriate setting for treatment.
3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

**Universal Protocol**

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**UP.01.01.01**

Conduct a pre-procedure verification process.

**UP.01.02.01**

Mark the procedure site.

**UP.01.03.01**

A time-out is performed before the procedure.

Appendix C: RCA

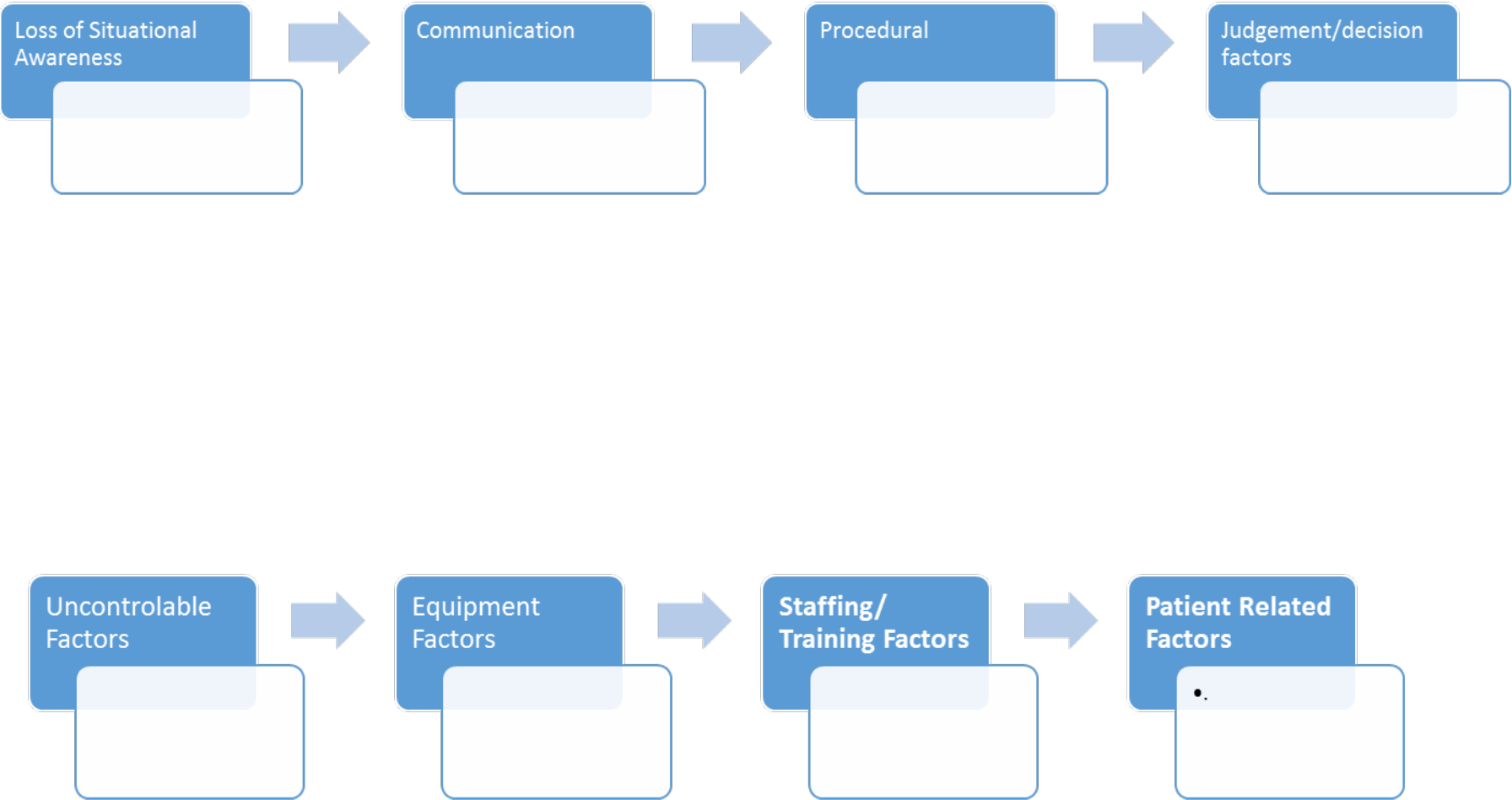
Narrative:

Key Factors:

Timeline:

| Date / Time | Description of Event as relates to RCA | Concerns Noted | Employee(s) involved |
|-------------|----------------------------------------|----------------|----------------------|
|             |                                        |                |                      |
|             |                                        |                |                      |
|             |                                        |                |                      |
|             |                                        |                |                      |
|             |                                        |                |                      |
|             |                                        |                |                      |
|             |                                        |                |                      |
|             |                                        |                |                      |

Cause and Effect Diagram (or process flow chart):



| Undesirable Outcome:  |                  |                      |             |                                                |             |              |
|-----------------------|------------------|----------------------|-------------|------------------------------------------------|-------------|--------------|
| Search for Causes:    | Cause Identified | Description of Cause | Human Error | Described Human Error and/or Variance from P/P | Causal Link | Take Action? |
| Patient Related       |                  |                      |             |                                                |             |              |
| Situational Awareness |                  |                      |             |                                                |             |              |
| Communication         |                  |                      |             |                                                |             |              |
| Proficiency           |                  |                      |             |                                                |             |              |
|                       |                  |                      |             |                                                |             |              |
| Judgment              |                  |                      |             |                                                |             |              |
| Training              |                  |                      |             |                                                |             |              |
|                       |                  |                      |             |                                                |             |              |
| Leadership            |                  |                      |             |                                                |             |              |
| Staffing              |                  |                      |             |                                                |             |              |
| Mechanical Failure    |                  |                      |             |                                                |             |              |
| Other                 |                  |                      |             |                                                |             |              |
|                       |                  |                      |             |                                                |             |              |



Action Plan

| Concerns | Action Plan | Responsible Party | Due Date | Status |
|----------|-------------|-------------------|----------|--------|
|          |             |                   |          |        |
|          |             |                   |          |        |
|          |             |                   |          |        |
|          |             |                   |          |        |
|          |             |                   |          |        |
|          |             |                   |          |        |
|          |             |                   |          |        |
|          |             |                   |          |        |
|          |             |                   |          |        |
|          |             |                   |          |        |

Participants:

Literature Review:

## Appendix D-1: PDSA Worksheet

### PDSA Worksheet

|                                                                                 |  |        |  |
|---------------------------------------------------------------------------------|--|--------|--|
| Topic:                                                                          |  |        |  |
| Person Completing Worksheet:                                                    |  | Date:  |  |
| Telephone/ Email:                                                               |  | Cycle: |  |
| Patient Safety Committee Members                                                |  |        |  |
| CNO/COO                                                                         |  |        |  |
| Patient Safety Officer                                                          |  |        |  |
| Infection Control Officer                                                       |  |        |  |
| Other Medical Staff                                                             |  |        |  |
| Other team members                                                              |  |        |  |
| <b>Aim:</b> (Describe the overall SMART goal that your team wishes to achieve.) |  |        |  |
|                                                                                 |  |        |  |
| <b>Plan:</b>                                                                    |  |        |  |
| 1. List the tasks needed to set up this test of change.                         |  |        |  |
|                                                                                 |  |        |  |
| 2. Predict what will happen when the test is carried out.                       |  |        |  |
|                                                                                 |  |        |  |

3. List the steps to develop the test-who, what, and when.

| Steps | By Whom | By When | Desired Outcome |
|-------|---------|---------|-----------------|
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |

**Do:** (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

**Study:** (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.

**Summarize what was learned: success, failure, unintended consequences, etc.**

**Act:** (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.

**Describe what modifications to the plan will be made for the next cycle based on what you learned.**

☐ Adapt: modify changes and repeat PDSA Cycle

☐ Adopt: expanding changes throughout organization

☐ Abandon: change approach and repeat PDSA cycle

## Appendix D-2: PDSA Monthly / Quarterly Progress Report

|                                                                                         |                    |                      |  |
|-----------------------------------------------------------------------------------------|--------------------|----------------------|--|
| Event:                                                                                  |                    |                      |  |
| Person Complete Report:                                                                 |                    | Date:                |  |
| Patient Safety Officer                                                                  |                    | Contact Information: |  |
| <b>Monthly / Quarterly Report</b>                                                       |                    |                      |  |
| <b>Items</b>                                                                            | <b>Description</b> |                      |  |
| 1. What is your goal?                                                                   |                    |                      |  |
| 2. Report on the PDSA cycle                                                             |                    |                      |  |
| 3. What system and practices are working well? Explain.                                 |                    |                      |  |
| 4. What areas for improvement did the data identify?                                    |                    |                      |  |
| 5. What barriers or system issues have been encountered implementing action activities? |                    |                      |  |
| 6. Action plans to address the barriers or system issues                                |                    |                      |  |
| 7. Lesson learned                                                                       |                    |                      |  |
| 8. Support needed                                                                       |                    |                      |  |
| 9. Additional discussion                                                                |                    |                      |  |
| Notes:                                                                                  |                    |                      |  |

## Appendix E: Checklist Example: Code Neuro

Code Neuro - New Item

EDIT

Save

Cancel

Paste

Cut

Copy

Attach File

ABC

Spelling

Commit

Clipboard

Actions

Spelling

Last Known Well Time

12 AM

00

Events prior to Code Neuro Call

Total NIHSS Score

Was head CT done

▼

Were Labs ordered

▼

Was Primary MD called

▼

Was Stroke Program Coordinator notified

▼

Name of recorder

Name of primary MD

Name of Primary RN

Name of Code Neuro Team RN

Supervisor

Was Patient transferred

▼


Save

Cancel

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

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## Appendix F: Policy Example

|                                                                                                                                         |                      |                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------|
|  <b>Saint Mary's</b><br><i>Regional Medical Center</i> | Policy and Procedure | <b>Perioperative Services</b><br><b>Labor &amp; Delivery/OR</b><br><b>Cath Lab</b><br><b>Interventional Radiology</b> |
| <b>Universal Protocol</b>                                                                                                               |                      |                                                                                                                       |

**POLICY:** Universal Protocol (Procedure Verification, Correct Site Management and Time Out For Invasive Procedures)

All patients undergoing a surgery or invasive procedure are to be considered at risk for the potential of a wrong patient, procedure or wrong site surgery/invasive procedure. The process to prevent wrong patient, wrong procedure and wrong site surgery or invasive procedure includes all required elements of the *Universal Protocol*. To assure that the correct procedure (operative or invasive) is performed on the correct patient and body part or site. Certain patients are considered at higher risk for error such as those undergoing multiple procedures with one or more physicians, those undergoing emergency procedures, or those patients that have unusual characteristics such as a physical deformity or massive obesity.

### DEFINITIONS:

**Procedure Verification:** Includes verification of patient, procedure and site and as applicable, any implants, diagnostic/radiology results, blood, devices and special equipment (as appropriate to the type of surgery or procedure) AND is applicable to all departments performing surgical or invasive procedures, inclusive of bedside procedures.

**Invasive Procedure:** Any procedure performed which involves a puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including but not limited to percutaneous aspirations, biopsies, cardiac and vascular catheterization, central line placements, epidurals and endoscopies. This policy does not apply to certain routine minor procedures such as peripheral IV line placement, insertion of an NG tube or urinary catheter insertion.

**Procedure Room:** Any room where a surgical or invasive procedure may occur to include the patient's bedside.

**Procedure Personnel:** The RN or credentialed personnel who are participating in the invasive procedure

**PROCEDURE:****A. General Information**

- Procedures NOT within the Scope of the Universal Protocol and this policy:
  - Venipuncture
  - Peripheral intravenous line placement
  - Insertion of nasogastric tube
  - Urinary catheter placement
  - ECT (electroconvulsive therapy)
  - Closed reduction
  - Radiation oncology
  - Lithotripsy (this does have laterality, but the stone is visualized during the procedure)
  - Dialysis (except insertion of the dialysis catheter)
- All other invasive procedures are within the scope of the Universal Protocol and this policy.
- Department staff and physicians participating in a surgical or invasive procedure will actively participate in the Procedure Verification process (to include pre-procedure verification, site marking, and time out) as described in this policy, to assure the correct patient, procedure and site (as applicable) is assessed prior to any surgical or invasive procedure. Staff will document the verification steps in the medical record.
- Anytime there is a discrepancy in the Procedure Verification process, the person discovering the discrepancy will re-verify all the previously completed steps against the surgery schedule, the history and physical, the permit, the patient and notify the physician and department manager. The procedure will not begin until clear verification of the patient, procedure and/or site is completed.
- All actual and "near miss" wrong patient, wrong procedure or wrong site procedures will be reported promptly to the Department Manager or designee and Risk Manager.

**B. Pre-Procedure Verification**

- Verification of the correct person using two identifiers (patient's name & date of birth), correct site, and correct procedure will occur with the patient/family/legal representative involved, awake and aware, if possible and documented.
- Additionally, persons responsible for scheduling the procedure, completing preadmission testing/assessment and admitting the patient will verify the procedure and site with the physician, physician's office or physician order.
- Pre-procedure verification will occur at the following times:
  - At the time the procedure is scheduled (to include implant information if applicable).
  - At the time of preadmission testing & assessment
  - At the time of admission or entry into the facility for a procedure, whether elective or emergent
  - Before the patient leaves the pre-procedure area (i.e. Same Day Unit or Pre-op Holding) or enters the procedure room

- Anytime the responsibility for care of the patient is transferred to another member of the procedural care team, (including the anesthesia providers), the above information will be communicated during the hand-off
- Additionally, in the pre-procedure area, procedure verification will include the following for patients undergoing a surgical or invasive procedure and be documented. All applicable items will be available in the procedure room/area and matched to the patient:
  - Identification of the procedure scheduled and identified in physician documentation
  - Presence of current, updated and complete History and Physical
  - Consent accurate, complete and signed by patient/representative
  - Provider assessment (MD, Nursing, PA, APN) and pre-anesthesia /procedural sedation assessment completed and documented
  - Marking of the procedure site by the physician prior to the procedure (if applicable)
  - Verification of the correct patient position
  - Availability and documentation of correct and labeled implants, diagnostic/radiology results, blood, devices and special equipment, or special requirements
- Scheduled procedures that involve anatomical sites that have laterality, surface (flexor, extensor), levels or specific digits or lesions, the word(s) left or right or bilateral will be written out fully on the procedure/operating room schedule and on all relevant documentation including the procedural consent or permit.

### C. Site Marking

- Site marking is conducted for all procedures involving incision or percutaneous puncture or insertion.
- The marking takes in to consideration anatomical laterality, the surface (flexor, extensor), the level (spine) or specific digit or lesion to be treated.
- In cases where bilateral structures are removed (such as tonsils or ovaries) the site does not need to be marked.
- If one side is definite and the other is possible, only mark the definite site (example: right ovary, possible left ovary, only mark the right side).
- The only exceptions to site marking are:
  - Midline, single organ procedures
  - When both bilateral structures are to be removed.
  - Endoscopies without laterality
  - Procedures when there is no pre-determined site of insertion, such as cardiac catheterization, interventional radiology and amniocentesis.
  - When the use of direct imaging (fluoro x-ray, ultrasound imaging, CT fluoro or MRI imaging) is utilized by a physician present from the time the site is selected through the completion of the procedure. This applies to all cases where the performing physician uses imaging to select and/or navigate and/or complete the procedure.
- The site marking is completed for all procedures involving incision or percutaneous puncture or insertion by the physician or proceduralist performing the procedure prior to the time the patient is moved in to the procedure room/location. The patient/family/legal representative should be involved in the site marking process.



- The physician or proceduralist will identify the patient (using the two patient identifiers) and verify the procedure and site with the patient/family/legal representative.
- In collaboration with the patient or patient's family member, the site will be marked with the initials of the physician performing the procedure using an indelible marker prior to the patient being transferred to the procedure/operating room unless the anatomical site is exempted per policy.
- The site initialed will be made at or adjacent to the incision site, and must be visible after the patient is prepped and draped and positioned in the final position.
- If the procedure involves multiple sides/sites during the same operation, each side and site must be initialed.
- Do not mark any non-operative site(s).
- In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure, is familiar with the patient, will be present when the procedure is performed, and is either qualified through a medical residency program or is a licensed individual who performs duties requiring collaboration or supervisory agreements with the licensed independent practitioner (i.e., PA, APN).
- For spinal surgery, a two-stage marking process will occur as follows:
  - The general level of the procedure (cervical, thoracic, lumbar, or sacral) will be initialed pre-procedure, along with an indication of the right vs. left if applicable.
  - Intra-operatively, the exact interspace will be precisely marked using the standard intraoperative x-ray.
- The site will not be marked with the letter "X" or the word "No."
- A new marking pen will be used for each patient
- If the patient refuses to be marked, procedural personnel will re-educate the patient regarding the importance of site marking and document. If the patient still declines to be marked, the procedural personnel will notify the physician, document what alternative means was utilized for marking. The patient's refusal to be marked must be resolved between the procedural physician and the patient prior to the invasive procedure.
- If the consent was signed and the patient was marked accordingly, and then it was discovered that the site was incorrect before the incision was made, the procedure can proceed at the discretion of the procedural physician. The procedural personnel as per hospital policy will document an occurrence report.

**D. Difficult to Mark Site:**

- Sites which are technically difficult or anatomically impossible to mark or minimal access procedures treating a lateralized internal organ, will apply the alternative process below:
- Examples: Arm in cast, ureters through a cystoscope, teeth, or premature infants.

- After verifying with the patient/family/legal representative that the patient identification and procedural information is correct, the procedural personnel will place a patient sticker and the procedural information on an orange band, indicating the 'side' with 'Left' or 'Right'.
- The orange band information will be verified and initialed by the physician, then placed on the patient's ankle. If the patient's anatomy or procedural draping prevents visualization of the band during the time out process then the band will be placed on the patient's wrist.
- The orange band will be removed in the PACU or post-procedure recovery location.
- Teeth. The physician will initial on the dental radiographs or dental diagram each tooth involved in the surgery/procedure. The dental radiograph or diagram will be used during the time-out before the procedure to identify the site during the "time-out".
- Premature Infants: The orange band will be applied as in no. 1 above.

#### **E. Time Out**

- The time out is the suspension of all other activities to permit all members of the surgical/ procedural team to focus on active confirmation of the required time out elements. The circulating nurse or technologist will initiate the time out, although any member of the team may do this. These elements include:
  - Correct Patient: Patient identification using the two patient identifiers (patient name & date of birth).
  - Correct Site: Verification/confirmation of procedure site and side as specified on the consent and visualization of site marking that it is correct and agrees with consent
  - Correct Procedure: Accurate procedure and consent form per physician's order.
  - Confirmation of antibiotic administration
  - Consensus with all team members that above information is correct
  - Documentation of the "time out/procedure verification" process
- The procedure will not be initiated until all members agree with all elements included in the time out.
- The time out will be initiated by the procedural personnel after the patient has been prepped and draped and immediately prior to the initiation of the procedure with all team members present in the room or at the bedside.
- Whenever there is more than one procedure performed by separate procedure teams, there will be a time-out completed and documented by the separate procedure teams. The time out will precede each individual procedure.
- If there is any discrepancy among the team members during the time-out, re-verification will occur with a review of the surgical/department procedure schedule, history and physical, procedure consent, radiology films, consultations and any other information available to validate the correct patient, procedure and site.

#### **F. Management Following Discovery of Wrong Patient/ Wrong Site/ Wrong Procedure**

- If, after induction of anesthesia, during the course of a surgical/invasive procedure, or after a surgical/ invasive procedure has been completed, it is determined that the procedure being performed or completed is the wrong patient, wrong procedure or at the wrong site, the surgeon/physician and anesthesiologist will:
  - Act in accord with the patient's best interests and to promote the patient's well-being.
  - Record the event accurately in the medical record.
- Procedural personnel will immediately inform the department manager who will immediately notify the Risk Manager per hospital policy.

#### **G. Fire Risk Assessment**

- A fire risk assessment shall be done prior to the start of all surgical procedures (Perioperative Areas)
  - Performed before start of procedure
  - All members of the team participating
  - Communicated during the "Time Out"
  - Documented in patient record
  - Fire Risk Assessment Tool:
    - A. Is an alcohol-based prep agent or other flammable solution being used preoperatively?
    - B. Is the surgical procedure being performed above the xiphoid process or in the oropharynx?
    - C. Is open oxygen or nitrous oxide being administered?
    - D. Is an electrosurgical unit, laser, or fiber-optic light being used?
    - E. Are there other possible contributors (i.e. defibrillators, drills, saws, or burrs)?

#### **H. Quality Improvement:**

Compliance with the Universal Protocol Policy will be monitored by conducting documentation/observation audits on a monthly basis.

#### **DOCUMENTATION:**

Surgical/Procedural Consent

Procedural/Surgical Nursing Record

Preprocedure Safety Checklist

#### **REFERENCE/EVIDENCE BASED PRACTICE:**

Prime HealthCare Policy: Universal Protocol: PeriOperative

AORN Position Statement: Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events; August 2015

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**AORN's Fire Safety Tool Kit**

The Joint Commission, 2016 National Patient Safety Goals.

The Joint Commission FAQ's 2009 Universal Protocol; November, 2008 Sentinel Event Alert-Wrong Site Surgery

Physician Insurer's Association of America (PIAA). Claims Data  
American Academy of Orthopedic Surgeons: Report on Wrong-Site Surgery Feb 1998

Bulletin of the American College of Surgeons, Vol. 87, No. 12, December 2002.

**AUTHOR/POLICY COORDINATOR:**

Tonya Lowry RN, CNOR, Perioperative Clinical Educator

Randy McElreath RN, MSN, Manger Perioperative Services

Krystal Flaniken RN, MSN, Director of Surgical and Perioperative Services

**APPROVAL:**

| <b>Committee Approvals</b>            | <b>Date</b> |
|---------------------------------------|-------------|
| Surgical Services Executive Committee | 12/13       |
| Procedural Safety Team                | 12/13       |
|                                       |             |
| <b>Committee Approvals</b>            | <b>Date</b> |
| Policy Committee                      | 6/16        |
| QUM                                   | 6/16        |
| MEC                                   | 8/16        |
| BOARD                                 |             |

**Origination date:** 09/01

**Reviewed/Revised:** 10/02, 12/02, 02/03, 06/03, 08/03, 10/03, 05/04, 04/05, 11/05, 08/06, 07/07, 05/08, 12/08, 02/09, 04/09, 04/10, 10/12, 12/13, 6/16

## Appendix D-2: PDSA Monthly / Quarterly Progress Report

|                                                                                         |                    |                      |  |
|-----------------------------------------------------------------------------------------|--------------------|----------------------|--|
| Event:                                                                                  |                    |                      |  |
| Person Complete Report:                                                                 |                    | Date:                |  |
| Patient Safety Officer                                                                  |                    | Contact Information: |  |
| <b>Monthly / Quarterly Report</b>                                                       |                    |                      |  |
| <b>Items</b>                                                                            | <b>Description</b> |                      |  |
| 1. What is your goal?                                                                   |                    |                      |  |
| 2. Report on the PDSA cycle                                                             |                    |                      |  |
| 3. What system and practices are working well? Explain.                                 |                    |                      |  |
| 4. What areas for improvement did the data identify?                                    |                    |                      |  |
| 5. What barriers or system issues have been encountered implementing action activities? |                    |                      |  |
| 6. Action plans to address the barriers or system issues                                |                    |                      |  |
| 7. Lesson learned                                                                       |                    |                      |  |
| 8. Support needed                                                                       |                    |                      |  |
| 9. Additional discussion                                                                |                    |                      |  |
| Notes:                                                                                  |                    |                      |  |


## Appendix E: Checklist Example: Injuries from Falls and Immobility

| Process Change                                                                                                                                     | In Place | Not Done | Will Adopt | Notes (Responsible & By When?) |
|----------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|------------|--------------------------------|
| Conduct fall and injury risk assessment upon admission                                                                                             |          |          |            |                                |
| Reassess risk daily and with changes in patient condition                                                                                          |          |          |            |                                |
| Implement patient-specific intervention to prevent falls and injury                                                                                |          |          |            |                                |
| Communicate risk across the team; use handoff forms, visual cues, huddles                                                                          |          |          |            |                                |
| Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks (vital signs) |          |          |            |                                |
| Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds                |          |          |            |                                |
| Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives                                                                         |          |          |            |                                |
| Incorporate multidisciplinary input for falls                                                                                                      |          |          |            |                                |
| Prevention from PT, OT, MD, RN and PharmD                                                                                                          |          |          |            |                                |
| Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient               |          |          |            |                                |
| Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls                                       |          |          |            |                                |

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

## Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

|                                                                                     |                                                                         |                                          |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------|
|    | HOSPITAL POLICY AND INFORMATION MANUAL                                  |                                          |
| <a href="#">PERSONAL PROTECTIVE EQUIPMENT POLICY</a><br><a href="#">Page 1 of 2</a> | Date Issued:<br>Date Last Revised:<br>Next Review Date:<br>Approved By: | 07/01 08/14<br>08/17<br>Policy Committee |

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Mercy Hospital;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQuIP5 - 1.5.1 and 1.5.2 Infection Control
- EQuIP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.


Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

|                                                                                     |                                                                         |                                          |  |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------|--|
|    | HOSPITAL POLICY AND INFORMATION MANUAL                                  |                                          |  |
| <a href="#">PERSONAL PROTECTIVE EQUIPMENT POLICY</a><br><a href="#">Page 2 of 2</a> | Date Issued:<br>Date Last Revised:<br>Next Review Date:<br>Approved By: | 07/01 08/14<br>08/17<br>Policy Committee |  |

Implementation:

#### Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

#### Process

##### Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports



Please revise and expand this template to meet your facility's needs.

**Facility Name:** Seven Hills Surgery Center

## QUALITY AND PATIENT SAFETY PLAN Template

DATE: 02/17/2020  
VERSION: XX



---

This plan was created and revised by the (Seven Hills Surgery Center) Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program**

**Facility name:** Seven Hills Surgery Center

876 Seven Hills Dr  
Henderson, NV 89052  
(702)914-2028

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## Commitment to Patient Safety

---

(Seven Hills Surgery Center) is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

### Mission, Vision, and Values

In support of our mission, vision, and values, (Seven Hills Surgery Center) Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

## Scope and Purpose

---

The scope of this Quality and Patient Safety Plan is organizational-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in (Seven Hills Surgery Center) are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, (Seven Hills Surgery Center) has developed this Patient Safety Plan.

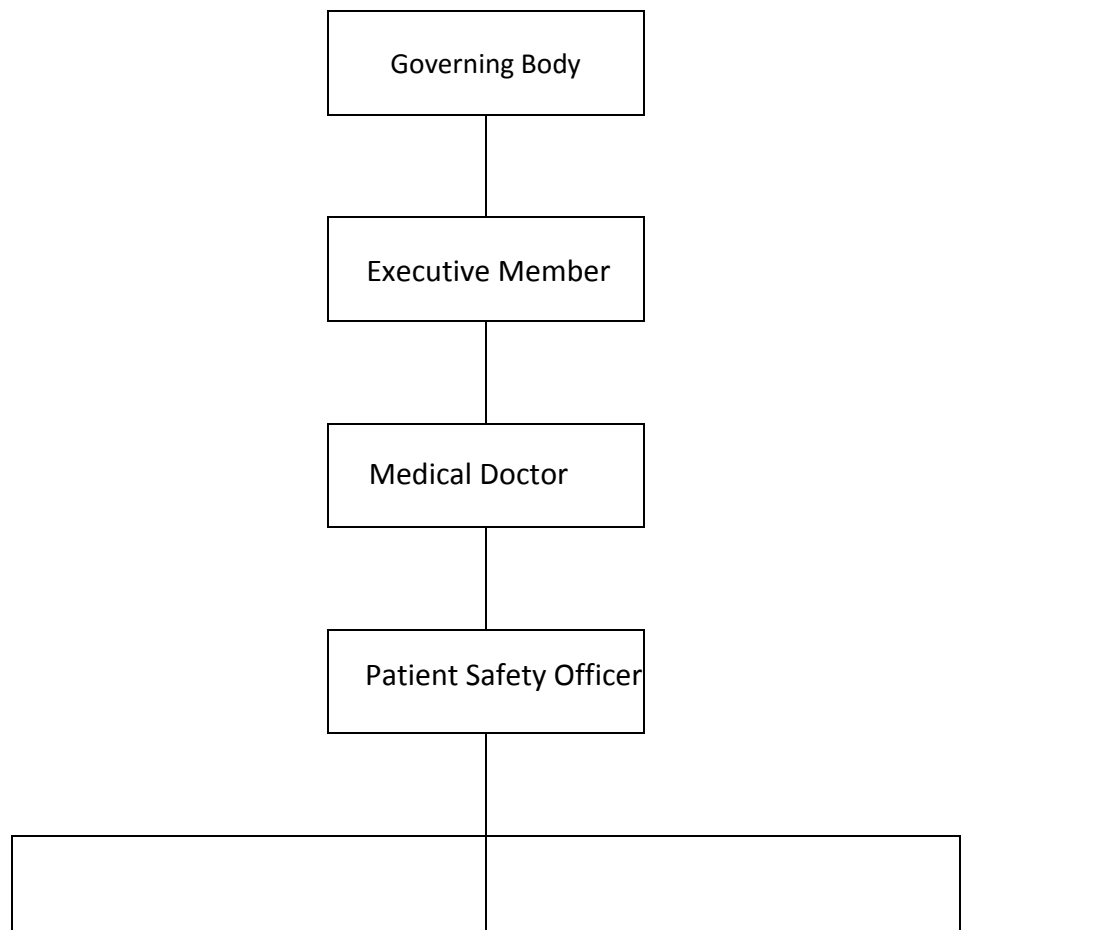
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

## Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



*Patient Safety and Quality Improvement Plan*

Pharmacist

Infection Control Officer

Administrator

**Roles and Responsibilities**

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

**Patient Safety Committee Responsibilities** (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar (quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);

(2) The number and severity of infections that occurred at the facility during the preceding calendar quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities (please revise as needed)

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities ([based on NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

RCA team leader Responsibilities (please revise as needed)

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.

*Patient Safety and Quality Improvement Plan*

- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities (please revise as needed)

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

*Patient Safety and Quality Improvement Plan*



A meeting agenda and minutes noting follow-up tasks will be kept.

## Objectives and Goals of the Quality and Patient Safety Plan

---

| Objective | Goals | Plan | Planned Completion Date | Responsible Party |
|-----------|-------|------|-------------------------|-------------------|
|           |       |      |                         |                   |
|           |       |      |                         |                   |
|           |       |      |                         |                   |
|           |       |      |                         |                   |
|           |       |      |                         |                   |
|           |       |      |                         |                   |
|           |       |      |                         |                   |

## Components and Methods

---

Pursuant to [NRS 439.837](#) and [NAC 439.917](#), within 45 days after reporting a sentinel event pursuant to [NRS 439.835](#), the medical facility shall conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

(Seven Hills Surgery Center) will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement that we will use to test the changes.



## Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

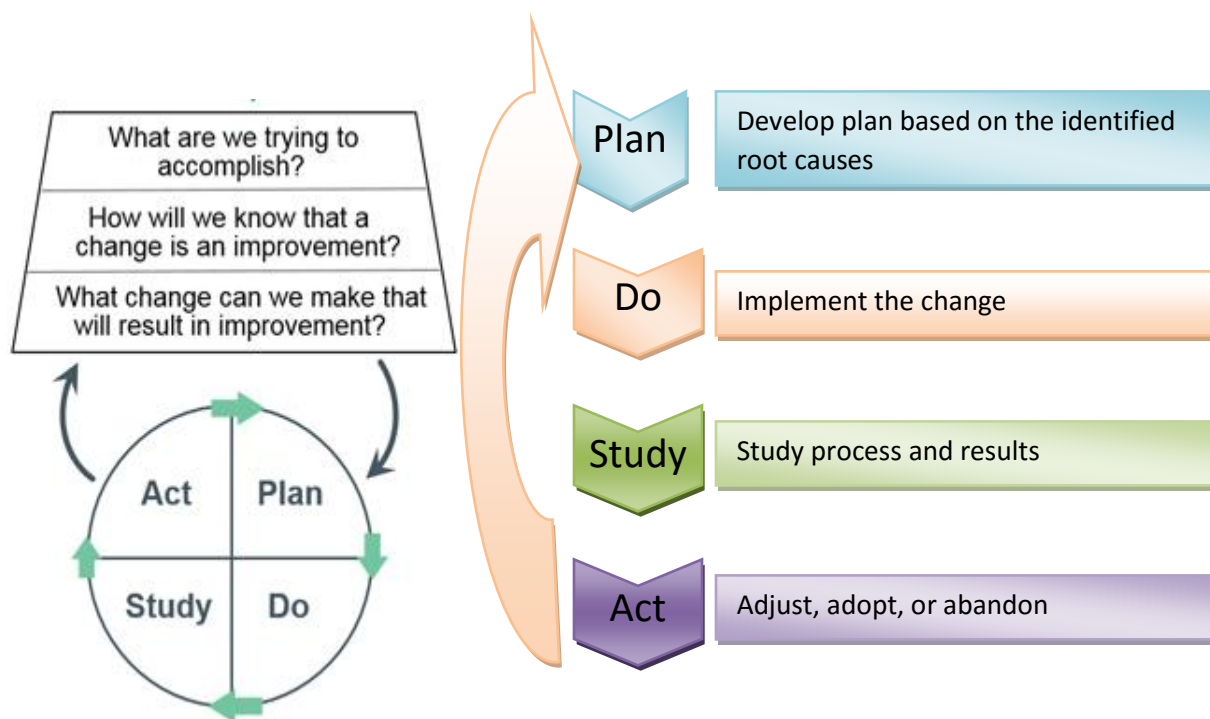
**Root cause analysis and action plan framework table**, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases.

**5 Whys** technique will be used in (Seven Hills Surgery Center) to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times.

*Patient Safety and Quality Improvement Plan*

## Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--Collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
  - What is the objective of the test?

*Patient Safety and Quality Improvement Plan*

- What are the steps for the test - who, what, when?
- How will you measure the impact of the test?
- What is your plan to collect the data needed?
- What do you predict will happen?
- Do--Make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

## Data Collection and Reporting

Data should drive any quality and patient safety effort. (Seven Hills Surgery Center) is using (internal processes) for tracking the sentinel events, healthcare infection data, and (Amkai) for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



### Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

| Monthly                                                                                          | Quarterly                                                                                                                                                                                                                            | Annually                                                                                           |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| 1) Sentinel event monthly report<br><br>2) Severity of infection report<br><br>3) RCA assessment | 1) Sentinel event quarterly report<br><br>2) Severity of infection report<br><br>3) Review and evaluate the measure of improvement of patient safety<br><br>4) Review and evaluate the measurement to prevent and control infections | 1) Quality and Patient Safety Plan update<br><br>2) Checklists and Policies reviewing and revising |

### Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

## Patient Safety Checklists and Patient Safety Policies

---

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a Infection Preventionist.

The patient safety checklists are listed in Appendix E. The following links provide some patient safety checklists for your reference-a checklist example is shown in Appendix E.

<http://www.hpoe.org/Reports-HPOE/Cklist PatientSafety.pdf>  
<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference- a policy example is shown in Appendix F).

## Approval of Patient Safety Plan

---

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

## Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools  
[http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/plan\\_do\\_study\\_act.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html)
- CQI 101 An Introduction to Continuous Quality Improvement:  
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2  
[https://www.jointcommission.org/sentinel\\_event.aspx](https://www.jointcommission.org/sentinel_event.aspx)
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety [http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee  
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>



## Appendix A: Terms and Definitions

---

**Patient Safety:** The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”  
[http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick\\_110.pdf](http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf)

**Sentinel event** ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

**Facility-Associated Infection:** ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

**Medical facility** ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

**Near miss:** An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Mandatory reporting:** Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

**Risk:** Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

**Preventable event:** Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Catheter Associated Urinary Tract Infection (CAUTI):** A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at [http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN\\_Manual\\_PatientSafetyProtocol\\_CURRent\\_b.pdf](http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRent_b.pdf).)

## Appendix B: Patient Safety Goals

| OBJECTIVE:                                                                                                                                                          | GOAL:                                                                                                                                                                                                                                                                                                                                                                          | Q3 2014                                                                                                                                                                                                                               | Q4 2014                                                                                                                                                                                                                                                                                                                | Q1 2015                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| <b>ACTION PLAN:</b>                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                       |
| <b>1. Create Systems</b> that anticipate errors & either prevent or catch them before they cause harm.                                                              | <ul style="list-style-type: none"> <li>a. Enhance retrospective chart review process.</li> <li>b. Establish an automated surveillance process.</li> <li>c. Conduct a proactive risk assessment in a high risk area.</li> </ul>                                                                                                                                                 |                                                                                                                                                                                                                                       | <ul style="list-style-type: none"> <li>Complete an in-depth analysis of risk point utilizing the methods of FMEA.</li> </ul>                                                                                                                                                                                           | <ul style="list-style-type: none"> <li>Implement Trigger Tools.</li> <li>Develop automated surveillance reports in Cerner.</li> </ul> |
| <b>2. Establish Structures</b> for reporting and a process for managing reports in the event reporting system.                                                      | <ul style="list-style-type: none"> <li>a. Implement new electronic Voluntary Reporting System &amp; participate in Patient Safety Organization.</li> <li>b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.</li> <li>c. Establish a process for providing feedback regarding reported events.</li> </ul> | <ul style="list-style-type: none"> <li>Implemented e-MERS &amp; PSO with UHC.</li> <li>Create process for reviewing &amp; closing reports in e-MERS.</li> <li>Create process for communicating outcome of reported events.</li> </ul> | <ul style="list-style-type: none"> <li>Increase number of events reported by 10%.</li> </ul>                                                                                                                                                                                                                           |                                                                                                                                       |
| <b>3. Develop a Culture of Safety</b> where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety. | <ul style="list-style-type: none"> <li>a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.</li> <li>b. Establish a recognition program that rewards safe practices.</li> <li>c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.</li> </ul>       |                                                                                                                                                                                                                                       | <ul style="list-style-type: none"> <li>Educate Medical staff, Hospital Wide Oversight &amp; the Quality Committees on the objectives and goals of the patient safety plan.</li> <li>Include patient safety presentation in monthly New Employee Orientation.</li> <li>Develop 'Great Catch' awards program.</li> </ul> | <ul style="list-style-type: none"> <li>Re-evaluate culture of safety and develop action plan.</li> </ul>                              |
| <b>4. Establish Safety Priorities &amp; Targets.</b>                                                                                                                | <ul style="list-style-type: none"> <li>a. Develop Patient Safety Dashboard that includes national measures and benchmarks.</li> <li>b. Facilitate the development of action plans associated with measures not meeting benchmarks.</li> <li>c. Assess and improve processes related to hand-off, transition and communication</li> </ul>                                       | <ul style="list-style-type: none"> <li>Complete 2014 Leapfrog Safety Survey.</li> <li>Develop method to track &amp; report departmental progress and compliance of RCA action plans.</li> </ul>                                       | <ul style="list-style-type: none"> <li>Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.</li> <li>Establish &amp; implement a plan to improve performance of each leap.</li> </ul>                                                                                                        |                                                                                                                                       |
| <b>5. Charter Safety Programs</b> through teams, workgroups or projects.                                                                                            | <ul style="list-style-type: none"> <li>a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities &amp; technologies are matched to strategic priorities for safe practices.</li> <li>b. Reduce and eliminate variation in care.</li> </ul>                                                                                                         |                                                                                                                                                                                                                                       | <ul style="list-style-type: none"> <li>Establish Patient Safety Council.</li> <li>Establish workgroups focused on medication safety, reducing patient falls &amp; hospital acquired pressure ulcers.</li> <li>Revise or develop policies, procedures and protocols.</li> </ul>                                         |                                                                                                                                       |

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

*Patient Safety and Quality Improvement Plan*



## Appendix D-1: PDSA Worksheet

### PDSA Worksheet

|                                                                                 |  |        |  |
|---------------------------------------------------------------------------------|--|--------|--|
| Topic:                                                                          |  |        |  |
| Person Completing Worksheet:                                                    |  | Date:  |  |
| Telephone/ Email:                                                               |  | Cycle: |  |
| Patient Safety Committee Members                                                |  |        |  |
| CEOs/CFOs                                                                       |  |        |  |
| Patient Safety Officer                                                          |  |        |  |
| Infection Control Officer                                                       |  |        |  |
| Other Medical Staff                                                             |  |        |  |
| Other team members                                                              |  |        |  |
| <b>Aim:</b> (Describe the overall SMART goal that your team wishes to achieve.) |  |        |  |
|                                                                                 |  |        |  |
| <b>Plan:</b>                                                                    |  |        |  |
| 1. List the tasks needed to set up this test of change.                         |  |        |  |
|                                                                                 |  |        |  |
| 2. Predict what will happen when the test is carried out.                       |  |        |  |
|                                                                                 |  |        |  |

3. List the steps to develop the test-who, what, and when.

| Steps | By Whom | By When | Desired Outcome |
|-------|---------|---------|-----------------|
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |

**Do:** (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

**Study:** (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.

**Summarize what was learned: success, failure, unintended consequences, etc.**

**Act:** (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.

**Describe what modifications to the plan will be made for the next cycle based on what you learned.**

☐ Adapt: modify changes and repeat PDSA Cycle

☐ Adopt: expanding changes throughout organization

☐ Abandon: change approach and repeat PDSA cycle

## Appendix D-2: PDSA Monthly / Quarterly Progress Report

|                                                                                         |                    |                      |  |
|-----------------------------------------------------------------------------------------|--------------------|----------------------|--|
| Event:                                                                                  |                    |                      |  |
| Person Complete Report:                                                                 |                    | Date:                |  |
| Patient Safety Officer                                                                  |                    | Contact Information: |  |
| <b>Monthly / Quarterly Report</b>                                                       |                    |                      |  |
| <b>Items</b>                                                                            | <b>Description</b> |                      |  |
| 1. What is your goal?                                                                   |                    |                      |  |
| 2. Report on the PDSA cycle                                                             |                    |                      |  |
| 3. What system and practices are working well? Explain.                                 |                    |                      |  |
| 4. What areas for improvement did the data identify?                                    |                    |                      |  |
| 5. What barriers or system issues have been encountered implementing action activities? |                    |                      |  |
| 6. Action plans to address the barriers or system issues                                |                    |                      |  |
| 7. Lesson learned                                                                       |                    |                      |  |
| 8. Support needed                                                                       |                    |                      |  |
| 9. Additional discussion                                                                |                    |                      |  |
| Notes:                                                                                  |                    |                      |  |

## Appendix E: Checklist Example: Injuries from Falls and Immobility

| Process Change                                                                                                                                    | In Place | Not Done | Will Adopt | Notes (Responsible & By When?) |
|---------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|------------|--------------------------------|
| Conduct fall and injury risk assessment upon admission                                                                                            |          |          |            |                                |
| Reassess risk daily and with changes in patient condition                                                                                         |          |          |            |                                |
| Implement patient-specific intervention to prevent falls and injury                                                                               |          |          |            |                                |
| Communicate risk across the team; use handoff forms, visual cues, huddles                                                                         |          |          |            |                                |
| Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs) |          |          |            |                                |
| Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds               |          |          |            |                                |
| Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives                                                                        |          |          |            |                                |
| Incorporate multidisciplinary input for falls                                                                                                     |          |          |            |                                |
| Prevention from PT, OT, MD, RN and PharmD                                                                                                         |          |          |            |                                |
| Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient              |          |          |            |                                |
| Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls                                      |          |          |            |                                |


Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

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## Appendix F: Policy Example

[Reference: Hospital Policies. MERCY Hospital. <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>]

|                                                                                   |                                                                         |                                          |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------|
|  | HOSPITAL POLICY AND INFORMATION MANUAL                                  |                                          |
| <b>PERSONAL PROTECTIVE EQUIPMENT POLICY</b><br>Page 1 of 2                        | Date Issued:<br>Date Last Revised:<br>Next Review Date:<br>Approved By: | 07/01 08/14<br>08/17<br>Policy Committee |

Key Words: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQuIP5 - 1.5.1 and 1.5.2 Infection Control
- EQuIP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Mercy Hospital will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.


Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Mercy Hospital for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

|                                                                                     |                                        |                                                                         |                                          |
|-------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------|------------------------------------------|
|    | HOSPITAL POLICY AND INFORMATION MANUAL |                                                                         |                                          |
| <a href="#">PERSONAL PROTECTIVE EQUIPMENT POLICY</a><br><a href="#">Page 2 of 2</a> |                                        | Date Issued:<br>Date Last Revised:<br>Next Review Date:<br>Approved By: | 07/01 08/14<br>08/17<br>Policy Committee |

Implementation:

#### Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

#### Process

##### Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

## Siena Heights Surgery Center:

### QUALITY AND PATIENT SAFETY PLAN

DATE: 02/01/2017  
VERSION: 20



This plan was created and revised by the Siena Heights Surgery Center Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

**Patient Safety Committee/Program**

**Siena Heights Surgery Center:**

2865 Siena Heights Dr Ste 200

P: (702) 586-3211 F: (702) 586-4922

*Patient Safety and Quality Improvement Plan*

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## Commitment to Patient Safety

[Siena Heights Surgery Center](#) is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

### Mission, Vision, and Values

In support of our mission, vision, and values, [Siena Heights Surgery Center](#)'s Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff [members](#), and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

## Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in [Siena Heights Surgery Center](#) are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, [Siena Heights Surgery Center](#) has developed this Patient Safety plan.

*Patient Safety and Quality Improvement Plan*

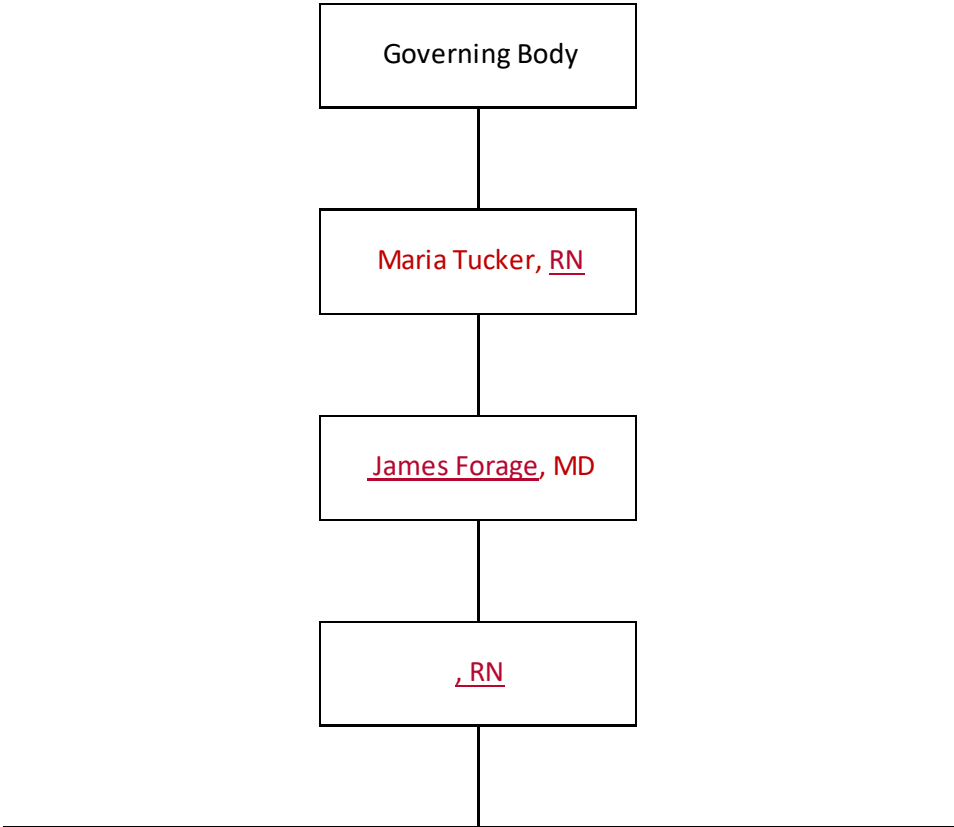
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

### Roles and Responsibilities

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



*Patient Safety and Quality Improvement Plan*



**Roles and Responsibilities**

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
  - The infection control officer of the medical facility;
  - The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
  - At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
  - One member of the executive or governing body of the medical facility.
- Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:
- The patient safety officer of the medical facility;
  - At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
  - The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below (Please modify them as needed.)

Patient Safety Committee Responsibilities (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:

*Patient Safety and Quality Improvement Plan*



- (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

#### Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

#### Patient Safety Officer Responsibilities ([based on NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

#### Infection Control Officer Responsibilities ([based on NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

#### RCA team leader Responsibilities

- Organize and coordinate the RCA process.

#### *Patient Safety and Quality Improvement Plan*

- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

#### RCA Facilitator Responsibilities

(Please provide the responsibilities here)

#### Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet quarterly to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the +.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.

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- Discussing and presenting possible changes in procedure to improve areas indicated.
- Identifying strengths and areas that need improvement.
- Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

## Objectives and Goals of the Quality and Patient Safety Plan

| Objective                        | Goals                                      | Plan                                                                                                                                                                   | Planned Completion Date | Responsible Party                 |
|----------------------------------|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------|
| Minimize risks & hazards of care | Attain zero patient injuries.              | All staff will monitor patient safety compliance: fall risks (wearing Yellow bracelets); Side rails up; Correct use of Velcro strap on OR bed.                         | 09/01/2017              | Kim L / All Staff                 |
| Reduction of patient infections  | Maintain zero infections.                  | All staff will monitor Infection Control Compliance. Use proven guidelines to prevent post-surgical infection.                                                         | 09/01/2017              | Maria Tucker, RN / All Staff      |
| Accurately identify patient      | Ensure you are positive of pt.'s identity. | Every staff in all areas use a minimum of 2 identifiers per patient.                                                                                                   | 09/01/2017              | Cheryl Loudermilk, RN / All Staff |
| Use all medications safely       | Prevent medication errors/interactions     | Pre-op nurse will ensure pre-op orders are understood by pt & if possible by S.O. and document understanding. Record correct info regarding patient's medication list. | 09/01/2017              | Cheryl Loudermilk, RN / All Staff |
| Prevent surgical mistakes        | Maintain zero surgical mistakes            | All OR staff ensure Time-Out compliance. Ensure surgeon marked correct place on body where surgery is to be done.                                                      | 09/01/2017              | Maria Tucker, RN / All Staff      |

## Components and Methods

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event."

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Siena Heights Surgery Center will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care- Improvement that we will use to test the changes.



**Root Cause Analysis**

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

**Root cause analysis and action plan framework table**, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

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**5 Whys** technique will be used in [Siena Heights Surgery Center](#) to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

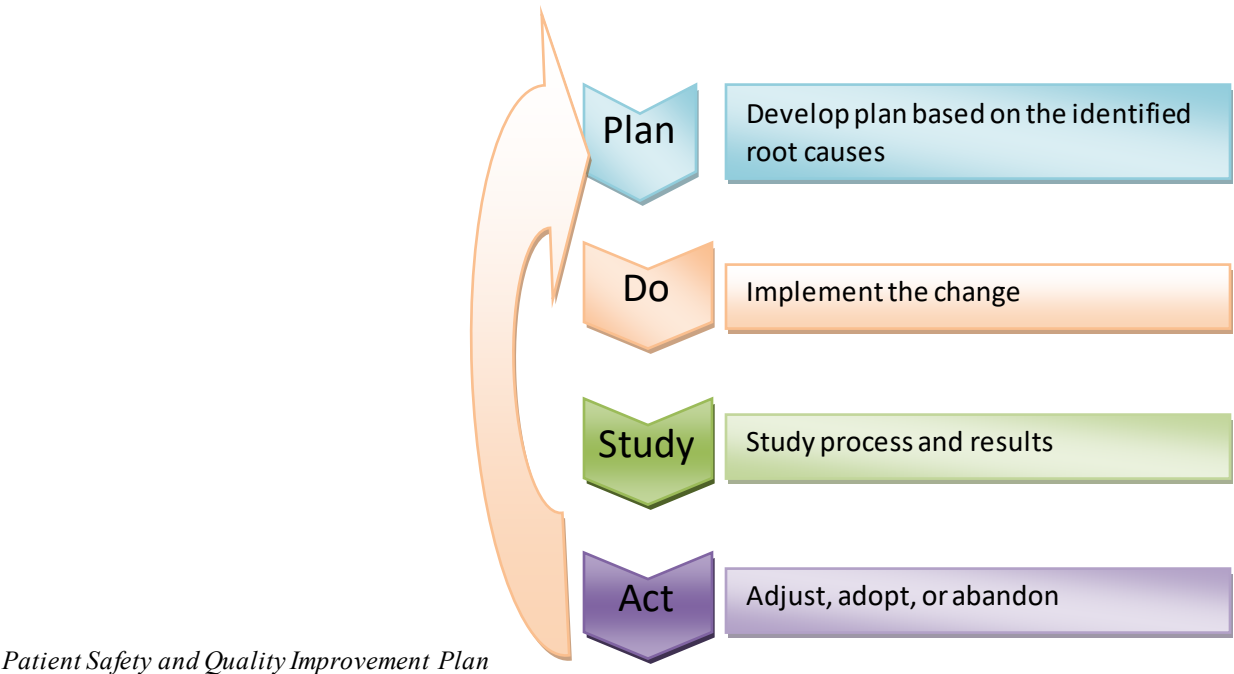
**Fishbone Diagram**

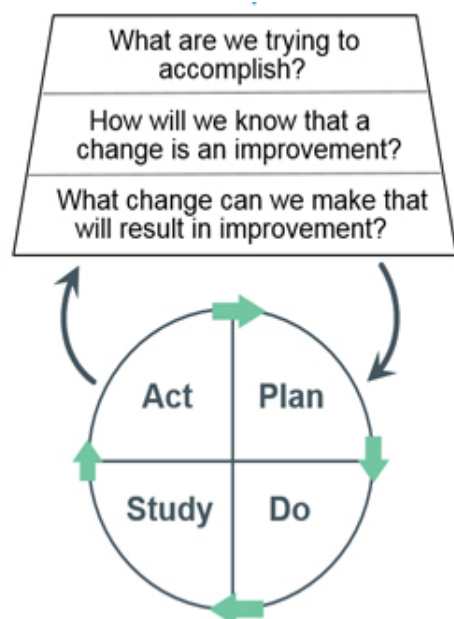
Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root-cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

**Model for Improvement**

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.





The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes, and answer the following questions.
  - What is the objective of the test?
  - What are the steps for the test - who, what, when?
  - How will you measure the impact of the test?
  - What is your plan to collect the data needed?
  - What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful,

*Patient Safety and Quality Improvement Plan*

look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. [Siena Heights Surgery Center](#) is using [Advantx](#) for tracking the sentinel events, healthcare infection data, and [facility log book data](#) for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

|         |           |          |
|---------|-----------|----------|
| Monthly | Quarterly | Annually |
|---------|-----------|----------|

|                                                                                          |                                                                                                                                                                                                                          |                                                                                                |
|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1) Sentinel event monthly report<br>2) Severity of infection report<br>3) RCA assessment | 1) Sentinel event quarterly report<br>2) Severity of infection report<br>3) Review and evaluate the measure of improvement of patient safety<br>4) Review and evaluate the measurement to prevent and control infections | 1) Quality and Patient Safety Plan update<br>2) Checklists and Policies reviewing and revising |
|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

Patient Safety Checklists and Patient Safety Policies

By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

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- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

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- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference—a checklist example is shown in **Appendix E**.)

[http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

## Approval of Patient Safety Plan

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According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

## Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>

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- Quality and Service Improvement Tools  
[http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/plan\\_do\\_study\\_act.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html)
- CQI 101 An Introduction to Continuous Quality Improvement:  
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2  
[https://www.jointcommission.org/sentinel\\_event.aspx](https://www.jointcommission.org/sentinel_event.aspx)
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety [http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee  
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

## Appendix A: Terms and Definitions

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**Patient Safety:** The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”  
[http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick\\_110.pdf](http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf)

**Sentinel event** ([NRS 439.830](#))

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1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

**Facility-Associated Infection:** ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))

**Medical facility** ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

**Near miss:** An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), *Patient Safety and Quality Improvement Plan*)

Serious Reportable Events in Healthcare 2009 Update.)

**Mandatory reporting:** Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985; 254(6):796-800.)

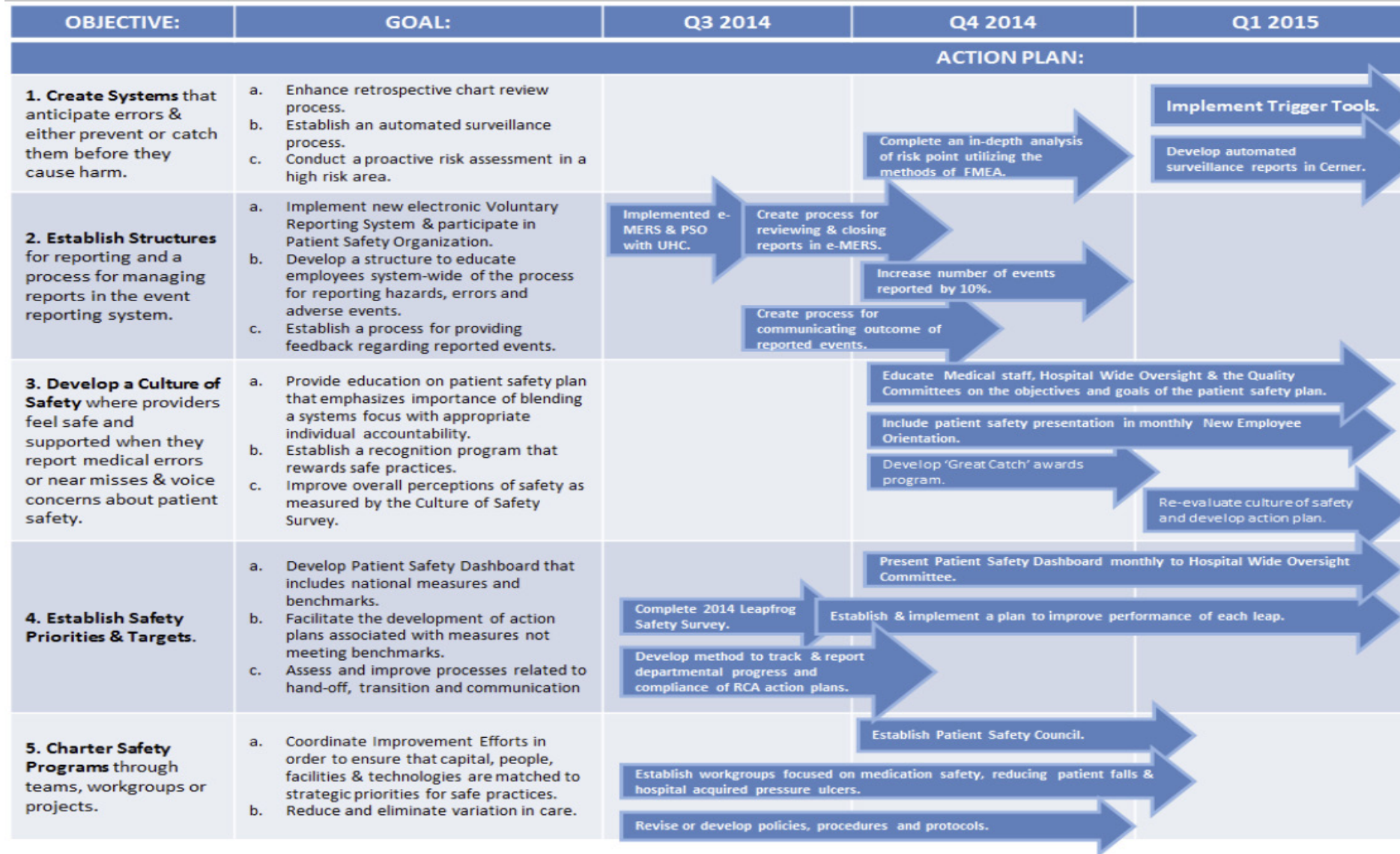
**Risk:** Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

**Preventable event:** Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Catheter Associated Urinary Tract Infection (CAUTI):** A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at [http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN\\_Manual\\_PatientSafetyProtocol\\_CathURRent\\_b.pdf](http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CathURRent_b.pdf).)

**Central Line Associated Bloodstream Infections (CLABSI):** Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

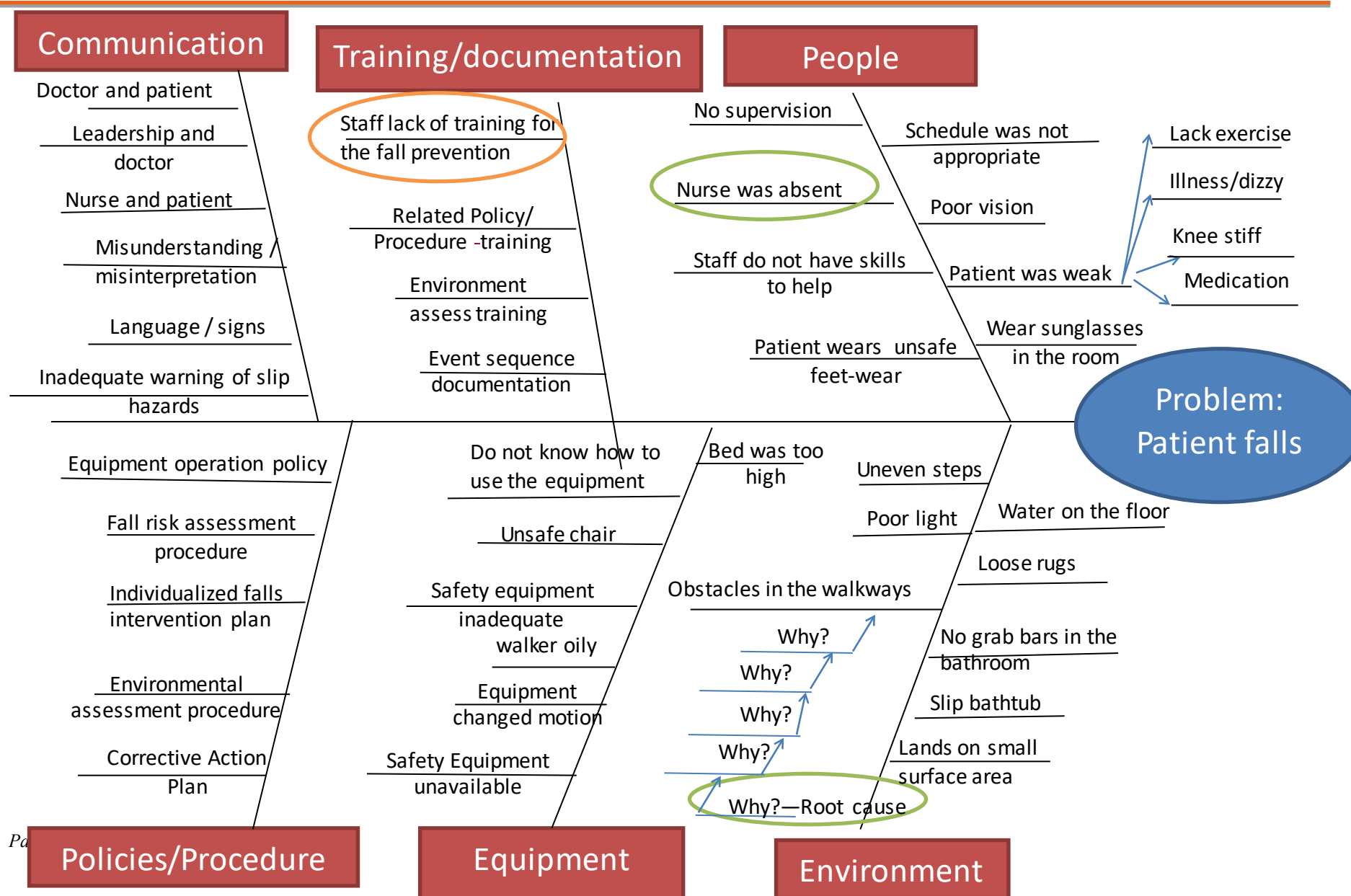
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Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

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## Appendix C: Fishbone Diagram



|                                                                                         |                                                                                     |                      |                                                                               |
|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------|
| Person Complete Report:                                                                 | Maria Tucker                                                                        | Date:                |                                                                               |
| Patient Safety Officer                                                                  | Maria Tucker, RN                                                                    | Contact Information: | <a href="mailto:mtucker@sienasc.com">mtucker@sienasc.com</a><br>(702)586-3211 |
| Monthly / Quarterly Report                                                              |                                                                                     |                      |                                                                               |
| Items                                                                                   | Description                                                                         |                      |                                                                               |
| 1. What is your goal?                                                                   | Decrease patient falls                                                              |                      |                                                                               |
| 2. Report on the PDSA cycle                                                             |                                                                                     |                      |                                                                               |
| 3. What system and practices are working well? Explain.                                 | Asking patient & family members questions pertaining to falls or risk of falls.     |                      |                                                                               |
| 4. What areas for improvement did the data identify?                                    | Continue to communicate with all staff caring for patient.                          |                      |                                                                               |
| 5. What barriers or system issues have been encountered implementing action activities? | A nurse may feel overwhelmed and forget to pass along fall risk info.               |                      |                                                                               |
| 6. Action plans to address the barriers or system issues                                | All staff to check if pt is a fall risk prior to taking over care for that patient. |                      |                                                                               |
| 7. Lesson learned                                                                       | Even with best of intentions communication is not always 100%                       |                      |                                                                               |
| 8. Support needed                                                                       | Daily AM huddle                                                                     |                      |                                                                               |
| 9. Additional discussion                                                                | n/a                                                                                 |                      |                                                                               |
| Notes:                                                                                  |                                                                                     |                      |                                                                               |

Appendix E: Checklist Example: Injuries from Falls and Immobility

| Process Change | In Place | Not Done | Will Adopt | Notes (Responsible & By When?) |
|----------------|----------|----------|------------|--------------------------------|
|----------------|----------|----------|------------|--------------------------------|


Patient Safety and Quality Improvement Plan



|                                                                                                                                                     |   |                          |   |                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|---|--------------------------|---|-------------------------------------------------------------------------------------------------------------|
| Conduct fall and injury risk assessment upon admission                                                                                              | X |                          |   | Every patient assessed by Pre-Op RN                                                                         |
| Reassess risk with changes in patient condition                                                                                                     | X |                          |   | Assessed by RN's in every area from admit to D/C.                                                           |
| Implement patient-specific intervention to prevent falls and injury                                                                                 | X |                          |   | Communicate with all team members involved in that pt's care. Pre-Op, OR, PACU Staff                        |
| Communicate risk across the team; use handoff forms, visual cues, huddles                                                                           | X |                          |   | Green "Fall Risk" bracelets initiated by Pre-op RN and communicated to OR & PACU Staff.                     |
| Round every 30 min to 1 hr for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs) |   |                          | X | Already initiated but not in writing yet. PACU RN will write a policy by and submit to the GB for approval. |
| Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives                                                                          | X |                          |   | Pain meds given as ordered by MD. Alternative pain relievers attempted prior to giving narcotics.           |
| Incorporate multidisciplinary input for falls                                                                                                       | X |                          |   | Input received via MD's, OR RN & staff and Charge Nurse via staff meetings & visualization.                 |
| Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient                | X |                          |   | Pre-Op RN includes families/caregivers in fall prevention education. PACU RN reiterates the education.      |
| Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls                                        | X | A fall has not occurred. |   | All Staff                                                                                                   |

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

## Appendix F: Policy Example

|                                                                                                                          |                                                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  HOSPITAL POLICY AND INFORMATION MANUAL |                                                                                                                                                                       |
| PERSONAL PROTECTIVE EQUIPMENT POLICY<br>Page 1 of 2                                                                      | <div>Date Issued: 01/08/14</div> <div>Date Last Revised: 01/17</div> <div>Next Review Date: 01/18</div> <div>Approved By: Governing Body</div> <div>Key<br/>Wor</div> |

ds: personal protective equipment, PPE, safety equipment,

Policy Applies to:

- All staff employed by Siena Surgery Center;
- Credentialed Specialists, Allied Health Professionals, patients, visitors and contractors will be supported in meeting policy requirements.

Related Standards:

- Infection and Prevention and Control Standards NZS 8134.3:2008
- Health and Safety in Employment Act 1992
- EQuIP5 - 1.5.1 and 1.5.2 Infection Control
- EQuIP5 - Standard 3.2 Criterion 3.2.1 Health and Safety

Rationale:

Siena Surgery Center will provide suitable personal protective equipment (PPE) when the risk to health and safety cannot be eliminated or adequately controlled by other means.

Definitions:

Personal protective equipment (PPE) means all equipment which is intended to be worn or held by a person to protect them from risk to health and safety while at work.

Examples of PPE include: protective footwear, gloves, hard hats/helmets, clothing affording protection from the weather, visibility clothing, eye and face protection.

Objectives:

- To ensure appropriate PPE is identified to minimize hazards not able to be controlled by elimination or isolation;
- To ensure fit for purpose PPE is provided at Siena Surgery Center for use by staff;
- To ensure adequate training in the use of PPE is provided;
- To monitor the use of PPE and evaluate effectiveness.

|                                                     |                                                    |                    |                |
|-----------------------------------------------------|----------------------------------------------------|--------------------|----------------|
| SienaSurgeryCenter                                  | Siena Surgery Center POLICY AND INFORMATION MANUAL |                    |                |
| PERSONAL PROTECTIVE EQUIPMENT POLICY<br>Page 2 of 2 |                                                    | Date Issued:       | 01/08/14       |
|                                                     |                                                    | Date Last Revised: | 01/17          |
|                                                     |                                                    | Next Review Date:  | 01/18          |
|                                                     |                                                    | Approved By:       | Governing Body |

Implementation:

#### Risk Management

Department Managers, the Occupational Health/ Infection Prevention and Control Nurse (OH/IPC Nurse) and Health and Safety/ Infection Control Representatives (HSIC reps) will in consultation with staff:

Ensure PPE requirements are identified when carrying out risk assessments of activities;

- Regularly review the risk assessment of activities if substances or work processes change;
- Identify the most suitable type of PPE that is required;
- Ensure PPE is available to those who need it;
- Inform staff of the risks involved in their work and why PPE is required;
- Monitor compliance.

#### Process

##### Manager's Responsibilities

Must ensure that:

- PPE requirements are considered when risks are assessed;
- Suitable PPE is provided and made accessible to employees;
- PPE is properly stored, maintained, cleaned repaired and replaced when necessary;
- Adequate information and training is provided to those who require PPE;
- PPE is properly used;
- Use of PPE is monitored and reviewed.

Employee's Responsibilities All employees must ensure that:

- They use PPE whenever it is required;
- Attend and comply with training, instruction and information;
- Check the condition of their PPE;
- Store, clean and maintain their PPE;
- Report losses, defects or other problems with PPE to their manager.

Evaluation:

- Staff health and safety orientation
- Environmental audits
- Incident reports

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## **SOUTH LYON MEDICAL CENTER**

### **PATIENT SAFETY COMMITTEE**

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**SUBJECT: Patient Safety Plan**

**CROSS: Medical Staff**

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**POLICY NO:**

**PAGE NO: 1 of 8**

**EFFECTIVE: 11/2002**

**REVISED:12/2019**

**APPROVED:**

---

**POLICY:** South Lyon Medical Center Patient Safety Plan

#### **PROCEDURE:**

1. The Medical Staff, with the approval of the Governing Board shall develop and implement a Patient Safety Plan to encompass all facets of patient care at South Lyon Medical Center. This includes Acute Care, Long Term Care and Rural Health Clinics.
2. The Medical Staff will appoint and submit to the Governing Board for approval the implementation of a Patient Safety Committee which will comprise at a minimum: a physician, a nurse, pharmacist, governing board member and risk manager. This committee shall:
  - a. function under the authority of the Medical Staff
  - b. meet monthly
  - c. investigate, report and formulate corrective actions related to alleged sentinel events
  - d. review medical equipment/devices safety and maintenance inspections
  - e. review and recommend actions related to medication events
  - f. review and investigate patient care related incident reports
  - g. review, investigate and recommend corrective actions for near-miss events
  - h. additional tasks as assigned by the Medical Staff
3. The Administrator shall appoint a Patient Safety Officer whose responsibilities are outlined in the position description.
4. The Patient Safety Plan shall include but not limited to the following items:
  - I. General:
    - a. Patient Safety involves a variety of clinical and administrative activities that health care organizations undertake to identify, evaluate, and reduce the potential for harm to beneficiaries and to improve the quality of health care. Effective medical/health care error reduction requires an integral approach and a supportive environment, in which patients, their families, organization staff and leaders can identify, manage and learn from actual and potential risks.
    - b. A successful patient safety program facilitates non-punitive, interdisciplinary approach to decrease unanticipated adverse health care outcomes. The organizational focus is on continued learning about risks and mitigation strategies and reengineering systems/processes to reduce the chance of human error. South Lyon Medical Center (SLMC) fosters and

supports an organizational environment that recognizes and acknowledges potential risks to patient safety and the occurrence of medical/health care errors. The patient safety program encourages medical error reporting in order to identify system or process failures and to enhance improvement strategies.

## II. South Lyon Medical Center (SLMC) Patient Safety Program

- a. The goal of the SLMC Patient Safety Program is to reduce the chance that the adverse effects of human error will harm patients. By creating and promoting a culture in which staff willingly report actual and near-miss patient safety related events without fear of disciplinary action, SLMC is encouraging these events to be freely identified. Once events have been identified, systems and processes can be analyzed and improved in order to prevent future recurrence. Improved systems and processes result in a safer patient care environment.
- b. SLMC Patient Safety Program focuses on system and process design rather than on the individual involved in a given patient safety related mishap. This paradigm is very different from that which prevails in the health care community at large. In the patient safety conscious culture, when an error occurs the response is not to ask “who”, but rather “why”. This new paradigm can exist in light of other organizational expectations associated with risk management, claims management and review of potentially compensable events (PCE) for which the facility may incur financial liability.
- c. All patient safety related reports require that an investigation be conducted to determine the cause(s) of the adverse event.
- d. A patient safety event that causes no patient harm requires no standard of care determination. However, any patient safety event that results in patient harm or potential patient harm, by definition, is a PCE. The patient safety officer will be notified of all PCE’s and these will be managed according to the established policies and procedures outlined in the Patient Safety Committee. Given the results of the investigation of the event, a Standard of Care determination will be required. Competency related information that arises through patient safety investigations will not be released outside of the Patient Safety Program except as noted in paragraph e below. The Patient Safety Program will consider process/system issues, while the Standard of Care determination reviews the individual’s performance.
- e. Although not a specific focus of the Patient Safety Program, concerns about a specific provider’s/professional’s competence may arise. Competence relates directly to an individual and, as such, requires an evaluation of the provider’s/professional’s performance, not an evaluation of the health care system. Competence will be addressed through the organization’s competence assessment, credentialing and privileging process. No individual competence related information will be released outside of the Patient Safety Program, except as noted in paragraph f below. If the competence assessment processes are determined to require review and improvement, such recommendations by the Patient Safety Committee and Medical Staff may be appropriate.
- f. The vast majority of errors are unintentional. No disciplinary action will be initiated against the individual(s) involved in an unintentional error. However, certain events, such as noted below, do warrant administrative, disciplinary or legal action. Should any of the following be discovered in the course of a patient safety event investigation, the Administrator and Medical Staff will be immediately informed of the circumstance and action taken beyond the scope of the Patient Safety Program:
  - 1) Criminal activity (e.g. assault and battery, etc)
  - 2) Intentional unsafe acts due to gross negligence or reckless behavior

- 3) Alleged patient abuse of any kind
- 4) Impairment due to medical and psychological conditions including alcohol or other drug abuse.

### III. South Lyon Medical Center Patient Safety Function.

- a. Integration of all patient safety related issues and processes under the auspices of a single committee/ functional team. This reduces duplication of effort and enhances program efficiency.
- b. Patient Safety Committee.
  - 1) Membership. Membership is outlined in NRS 439.875; 1) The infection control officer, 2) The patient safety officer, 3) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility. And 4) One member of the executive or governing body of the medical facility.
  - 2) Chairperson. The chairperson shall be a nurse or physician.
  - 3) Committee minutes/reports. The committee minutes/reports will summarize the organizations patient safety activities to include, as a minimum:
    - a. Analysis of all clinical and non-clinical reported events, trends and lessons learned.
    - b. Actions necessary for organizational process/systems improvements as appropriate.
    - c. Proactive patient safety error reduction activities.
    - d. Progress related to risk assessments, prospective analysis and root cause analysis action plan implementation and effectiveness, according to established time-lines.
    - e. Patient Safety Committee minutes/reports will be forwarded to the Medical Staff Committee and the Governing Board quarterly. Recommendations associated to patient safety will be forwarded to the Medical Staff for implementation as appropriate.
- c. Management of Patient Safety Information.
  - a. The focus of patient safety data collection and reporting is to improve organizational systems and to provide the safest care possible. The information and data amassed through reporting, investigation and evaluation will be confidential and reported through the Medical Staff Quality Assurance process.
  - b. Data trend analysis will include, but not be limited to, the following:
    - 1) Sentinel Events or actual or alleged.
    - 2) Medication errors and fall.
    - 3) Equipment malfunctions.
    - 4) Preventive/corrective interventions
  - c. Ad hoc committees may be assigned by the Medical Staff regarding competency investigations related to a patient safety related event to insure that peer status is maintained throughout any investigation. All information obtained will remain confidential under the auspices of Medical Staff Quality Assurance.

### IV. Patient Safety Event Management.

- a. Event identification. A patient safety event is any incident that occurred (actual event) or almost occurred (near miss) that caused or had the potential to cause harm to a patient. Identification and reporting of near misses and adverse events, including those that result from practitioner/professional error, should be encouraged as an expectation of everyday practice. The three types of patient safety events include near miss, adverse events and sentinel events.
- b. Near Miss. A near miss is an event or situation that could have resulted in harm to a patient, but did not, either by chance or through timely intervention. The event was identified and resolved before reaching the patient. Because near misses generally occur more frequently than actual adverse events, proactive analyses of near misses provide a tangible opportunity to improve the system without having to experience an actual adverse event. Staff should be encouraged to report near miss events for the purpose of analysis and identification of methods improvement.
- c. Adverse Event. An adverse event is an occurrence associated with the provision of health care or services that may or may not result in harm to the patient. Adverse events may be due to acts of commission or omission. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no harm or permanent effect to the patient.
- d. Sentinel Event. A sentinel event is an unexpected occurrence involving death, serious physical or psychological injury, or the risk thereof. **Serious injury** specifically includes loss of limb or function. The phrase “or risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and proactive response on the part of the organization.

## V. Event Documentation and Reporting.

1. Prevention of harm to patients is everyone’s responsibility and reporting all potential and/or actual patient safety events is a performance expectation of all organizational staff. Anyone with knowledge of a patient safety event not only may, but should, report it.
  - a. Immediate actions.
    - 1) Upon identification of a actual patient safety event, the staff member will immediately perform necessary health care interventions to protect and support the patient’s clinical condition. The patient’s attending physician and other physicians, as appropriate, will be contacted as soon as possible to report the incident and provide an update on the patient’s current clinical status.
    - 2) As appropriate to the event, the staff will initiate all physician directed orders and take other necessary health care interventions to contain the risk to others, and to preserve event-related materials that may require further investigation. Examples of physical information preservation include: removal and preservation of a blood unit for a suspected transfusion reaction; preservation of IV tubing, fluid bag, and/or IV pump for a patient with a severe drug reaction from a IV medication. Preservation of information also includes documenting the facts regarding the event in the patient’s medical record according to organizational policy and procedure.

- 3) If the patient safety event involves serious physical or psychological injury, unexpected death, or qualifies as a sentinel event, the appropriate department director will be notified immediately. If such events occur after hours, the administrative on-call staff will be notified immediately. Individuals notified will ensure proper notification of senior management is accomplished in a timely fashion.

b. Documentation and Internal Reporting.

- 1) Any individual in any department who identifies a potential (e.g. near-miss) or actual patient safety event will immediately notify their immediate supervisor and will initiate a Incident Report. This report will contain concise, factual, objective and complete details about the event.
- 2) Incident Reports or in the case of medication errors, a Adverse Drug Event Report will be forwarded to the department director within 24 hours of the discovery of the event or the first duty day following a weekend or holiday. The department director will review the report, add any additional relevant information, and forward it to the Patient Safety Officer, or designee, within 24 hours of receipt.
- 3) The Patient Safety Officer (PSO), or designee, will review all incident reports and ADE reports. In addition, the PSO will determine what specific actions are necessary to further evaluate the event. If the event is a sentinel event, the PSO will immediately notify the Administrator and Risk Manager and activate a Root Cause Analysis Team from the Patient Safety Committee and others as deemed appropriate to investigate the event.
- 4) If the patient safety event is an intentional unsafe act that results from gross negligence or possible criminal activity, the event shall be reported to the appropriate authorities for investigation.
- 5) Some events fall within the definition of both an adverse event and an intentional unsafe act. For example, infant abduction would be both a crime and a reportable Sentinel Event that require Root Cause Analysis. In cases that appear to be both a adverse event and an intentional unsafe act, primary authority and responsibility for dealing with the event belongs to the Administrator and Risk Manager. This is beyond the scope of the Patient Safety Program. The PSO will coordinate a review of the systems and processes implicated in the actual or potential unsafe act, to include conducting a root cause analysis, if applicable, but will defer to a separate investigation with respect to the culpability of any persons involved in the event.
- 6) External reporting requirements. All incidents meeting the definition of a Sentinel Event must be reported to the State Health Department and Bureau of Licensure. Reports must be completed within the time frame as outlined in policy and procedure.

VI. Patient Safety Event Analysis.



Event analysis assists in the discovery of the root causes and/or contributing factors associated with the patient safety event. Tracking and trending of data allows the Patient Safety Committee and Medical Staff to identify familiar trends or circumstances so that system or process issues can be identified and improved.

- a. Aggregate review analyses. Aggregate review consists of examining data elements for common trends or patterns within the group. The use of aggregated review serves two purposes. It allows for wider applicability of the analyses (i.e., trends or patterns that were not noticeable in an individual case analysis become more obvious as the number of cases increases). In addition, it more clearly defines specific data elements in a recurring problem and encourages prudent use of the time and expertise of the organization staff associated with evaluation and corrective action.
- b. Root Cause Analysis. A root cause analysis must be conducted and an action plan completed for all actual sentinel events. The Patient Safety Committee will formally designate a root cause analysis team to conduct a thorough and credible root cause analysis on all sentinel events. A Root Cause Analysis (RCA) is the process for identifying the basic and/or contributing casual factor(s) associated with patient safety events. The review is interdisciplinary and includes those who are closest to the process, but typically not those directly involved in the specific event. Those directly involved may be consulted for event-related information if appropriate. The RCA focuses on systems and processes, not individual performance. It identifies changes that could be made in the systems and processes to improve performance and to reduce the risk of adverse events, or the recurrence of near misses, with the ultimate goal of reducing and/or eliminating patient harm.
- c. Root Cause Analysis Action Plan. Once the RCA has been completed, a detailed action plan must be developed to enumerate the risk reduction strategies that the organization intends to implement to prevent the recurrence of similar events. The action plan should address responsibility for implementation, oversight, pilot testing (if appropriate), timeliness, and the specific metrics to be employed in evaluating the effectiveness of the actions taken.
- d. The RCA action plan will be submitted to the Medical Staff for approval.
- e. Follow-up review. All RCA action plans will be reviewed at a minimum of 6 months following implementation to address the effectiveness of the improvements implemented by the organization. These findings will be reported to the Medical Staff and Governing Board.

## VII. Patient Safety Event Communication.

Administration and all staff are reminded that all data compiled as part of the Patient Safety Program are QA information and protected from disclosure and must be marked as Quality Assurance Document.

- a. Staff involved in a patient safety event. Any staff member reporting and/or directly involved in a patient safety event that caused patient harm will receive support and assistance from their supervisor to facilitate the staff member's professional and emotional needs related to the patient safety event. Management efforts and activities will focus on improving the systems and processes that may have contributed to the event rather than disciplining those involved.

- b. Reporting a patient safety event. Staff members and supervisors who submit patient safety event reports will receive timely feedback on the actions being taken as a result of their report.
- c. Patient/family affected by a patient safety event. In cases involving an unanticipated outcome of care, a qualified health care provider will inform the patient and/or his/her family member(s) within seven (7) days of discovery of the event. This information is provided as a matter of policy and does not affect any rights or obligations in legal or administrative proceedings. Under no circumstances will QA-protected information be released or provided to the patient/family member.
- d. The Patient Safety Officer, or designee, is responsible to ensure that the provider and patient/family member communication takes place. The designated primary communicator will document in the patient's medical record what was communicated to the patient/family member, the patient/family member's response, and any other pertinent information. It shall be the responsibility of the affected patient's primary care physician or Chief of the Medical Staff or Vice Chief of the Medical Staff to make the initial and subsequent notification.
- e. In most cases, facts surrounding the patient safety event that affect the patient can and should be disclosed to the patient/family member by the provider.
- f. Any specific questions relative to disclosure of information associated with unanticipated adverse outcomes should be referred to the organization's legal representatives.

## VIII Patient safety Education and Training

- a. All staff shall receive patient safety education and training during their initial new employee orientation and on an annual and as-needed basis, regarding job-related aspects of patient safety and staff specific roles and responsibilities to actively support patient safety policy.
- b. Community education. Patients and potential patients/family members shall be educated concerning their role in helping to facilitate the safe delivery of care. Methods include but are not limited to; public forums, newspaper articles, addressing specific community groups and organizations.
- c. **Checklists have been developed and implemented in several different formats that range from facility policies, department checklists and medical record audits. These checklists and policies include but are not limited to; correct patient identification and verification, foley catheter criteria, informing patients of Healthcare Acquired Infections (HAI's) or Facility Acquired Infections (FAI's), hospital inpatient information sheets related to HAI's and hand hygiene and respiratory etiquette and patient information regarding discharge planning, medication reconciliation and request that providers indicate the use or reason for each prescription that is issued.**
  - a. **On or before July 1 of each year a report will be submitted to the Director of the Legislative Counsel Bureau which includes the development, revision and usage of patient safety checklists and policies.**

## IX Confidentiality of Medical Quality Assurance Information.

As with other medical QA documents, any information, records, reports, minutes, and other documents directly associated with patient safety activities are protected under

10 USC 1102. In discussing medical information with family members, staff shall also comply with other applicable restrictions on nonconsensual disclosures, including those under the Privacy Act, 5 USC 552a. As a general rule under the Privacy Act, information regarding a patient's condition shall not be provided to others without the patient's consent.

**NEVADA ENDOSCOPY MANAGEMENT, INC  
GASTROENTEROLOGY CONSULTANTS, LTD  
RENO ENDOSCOPY CENTER, LLC  
SOUTH MEADOWS ENDOSCOPY CENTER, LLC  
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**POLICY AND PROCEDURE MANUAL**

**Policy:** Patient Safety Officer and Patient Safety Committee

**Owner:** Center

**Date last updated:** Revised 2/2020

**Purpose:** To ensure the ongoing safety of our patients.

**Patient Safety Officer:** The Manager of Quality Management, shall serve as the Patient Safety Officer. In the event the Manager of Quality Management is not available, the Director of Center Operations shall serve as the Patient Safety Officer. The duties of the Patient Safety Officer include, but are not limited to, the following:

1. Registration with the State of Nevada Health Division "Sentinel Events Registry Contact."
2. Serve on the Patient Safety Committee.
3. Supervise the reporting of all sentinel events alleged to have occurred within the Center to the Nevada State Health Division, pursuant to NRS 439.835.
  - a. The Safety Officer will report to the State within thirteen (13) days of receiving notification, becoming aware or discovering a sentinel event, using the electronic State Report Form.
4. Reviews, investigates and evaluates all sentinel events for cause, trend and prevention.
5. Takes any action necessary to ensure the safety of patients as the result of any review, investigation, and evaluation of all sentinel events.
6. Reports to the Patient Safety Committee all sentinel events and action taken.

**Patient Safety Committee:** The committee shall include the Patient Safety Officer, the RN Director of Center Operations, and the Medical Director/Administrator of the Center. The committee will meet monthly and report to the Center Board of Managers Meeting quarterly. The duties of the Safety Committee will include, but not be limited to:

1. Receive reports from the Patient Safety Officer of all sentinel events.
2. Evaluate the actions of the Patient Safety Officer in connection of all reports of sentinel events.
3. Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.
4. Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections in the facility.
5. 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.
6. At least once each calendar quarter, report to the governing body of the medical facility regarding:
  - a. The number of sentinel events that occurred at the medical facility during the preceding calendar quarter;
  - b. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter;
  - c. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

Approved Board of Managers REC/ SEC 10/11/11; CEC; Approved by Director of Center Ops, QM Manager, and Executive Director 2/14/19

*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.*

- d. Adopt patient safety checklists and patient safety policy; review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Refer to:

- Procedure, Adverse and Sentinel Event Policy
- Patient Safety Policy
- Infection Control Policy
- Nevada Sentinel Events Registry at [http://health.nv.gov/Sentinel\\_Events\\_Registry.htm](http://health.nv.gov/Sentinel_Events_Registry.htm).
- NRS 439.830 – 439.845; 439.875

Approved Board of Managers REC/ SEC 10/11/11; CEC; Approved by Director of Center Ops, QM Manager, and Executive Director 2/14/19

*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.*

# **Southern Hills Hospital and Medical Center**

## **Patient Safety Plan**

**Updated: 3/5/18, 2/18/19**

**Quality of Care Committee: 3/15/18,**

**Medical Executive Committee: 3/15/18;3.21.2019**

**Board of Trustee: 3/22/2017, 3/21/18 ;3.27.2019**

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## I. **Introduction**

### ***Purpose, Scope and Responsibility***

- ✓ Purpose:
  - To define the essential components of the Patient Safety Program at Southern Hills Hospital, which is committed to ensuring a safe environment and reliable care processes.
  - To cultivate a culture of patient safety through the ongoing promotion of a safe practices and personal accountability.
- ✓ Scope: Patient safety is everyone's responsibility. The Southern Hills Hospital Patient Safety Program covers all activities and functions relating to patient safety at all sites and services within the organization.
- ✓ Responsibility: Leaders, employees, members of the medical staff, students and volunteers are to be familiar with and involved in the Patient Safety Program.

### ***Participation in Patient Safety Organization***

- ✓ Southern Hills Hospital is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided to the Hospital. To further this objective, the Hospital contracted with HCA Patient Safety Organization, LLC ("HCA PSO, LLC"), a federally certified Patient Safety Organization ("PSO"), to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment. Generally speaking, patient safety work product ("PSWP") is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act ("FOIA"), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act ("PSQIA") and its associated regulations. (See 42 CFR § 3.204, *Privilege of patient safety work product*; and 42 CFR § 3.206, *Confidentiality of patient safety work product*.) The Hospital will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses, patient safety communications, quality reviews, and other documents aimed at improving patient safety. Documents will be submitted in a standardized format to allow for comparison with like providers. As part of this effort, the Hospital will operate a Patient Safety Evaluation System ("PSES") designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC. The PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes. Designated Hospital personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

### ***Definition of Terms***

#### **Accountability:**

An obligation or willingness to accept responsibility for one's actions.



|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <u>Adverse Event:</u>       | Event under the control of a provider which has caused harm and requires a new or modified physician order for management of the patient's health care. See Policy RM19: Sentinel Event for specific event list and RM13: Disclosure of Adverse Events.                                                                                                                                                                                       |
| <u>Hazardous condition:</u> | Any set of circumstances (exclusive of the disease or condition in which the patient is being treated), which significantly increases the likelihood of serious adverse outcome.                                                                                                                                                                                                                                                              |
| <u>Healthcare FMEA:</u>     | Healthcare Failure Mode and Effects Analysis: A proactive model for addressing potential risks within the organization.                                                                                                                                                                                                                                                                                                                       |
| <u>Human Error:</u>         | An unintended act, or failure to act, that results in actual or potential patient injury, harm or adverse event in the process of care delivery.                                                                                                                                                                                                                                                                                              |
| <u>Near miss:</u>           | Any process variation that did not affect the patient outcome, but for which a recurrence carries a significant chance of serious adverse outcome.                                                                                                                                                                                                                                                                                            |
| <u>Non-punitive:</u>        | No punishment or disciplinary action imposed for specific error.                                                                                                                                                                                                                                                                                                                                                                              |
| <u>Patient injury:</u>      | Major permanent loss of function, sensory, motor, or intellectual impairment not present at admission, requiring continued treatment or lifestyle change. When "major permanent loss of function" cannot be immediately determined, patient injury is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first. |

Patient safety event:

All adverse events or potential adverse events that are deemed preventable and Healthcare associated infections as defined by the CDC that are deemed to be preventable.

PSQIA

The Patient Safety and Quality Improvement Act (PSQIA) of 2005, Pub. L. 109-41, 42 U.S.C. 299b-21-b-26 (for which the final rule implementing the regulations became effective on January 19, 2009), was enacted in response to growing concern about patient safety in the United States and the Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System*. The goal of the Act is to improve patient safety by encouraging voluntary and confidential reporting of events that adversely affect patients.

PSO

A Patient Safety Organization (PSO) means a private or public entity or component thereof that is listed as a PSO by the Secretary of Health and Human Services. A health insurance issuer or a component organization of a health insurance issuer may not be a PSO. The PSO enters into bona fide contracts, each of a reasonable period of time, each with a different provider for the purpose of receiving and reviewing patient safety work product.

PSES

A Patient Safety Evaluation System (PSES) means the collection, management, or analysis of information for reporting to or by a PSO.

PSWP

Patient Safety Work Product (PSWP) (1) Except as provided in (2) below, patient safety work product means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material) (i) Which could improve patient safety, health care

quality, or health care outcomes; and (A) Which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO, and such documentation includes the date the information entered the patient safety evaluation system; or (B) Are developed by a PSO for the conduct of patient safety activities; or (ii) Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system. (2)(i) Patient safety work product does not include a patient's medical record, billing and discharge information, or any other original patient or provider information; nor does it include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a PSO shall not by reason of its reporting be considered patient safety work product. (ii) Patient safety work product assembled or developed by a provider for reporting to a PSO may be removed from a patient safety evaluation system and no longer considered patient safety work product if: (A) The information has not yet been reported to a PSO; and (B) The provider documents the act and date of removal of such information from the patient safety evaluation system. (iii) Nothing in this part shall be construed to limit information that is not patient safety work product from being: (A) Discovered or admitted in a criminal, civil or administrative proceeding; (B) Reported to a Federal, State, local or Tribal governmental agency for public health or health oversight purposes; or (C) Maintained as part of a provider's recordkeeping obligation under Federal, State, local or Tribal law.

Reliability:

The extent of consistent performance over time.

**Sentinel Event:**

A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, and/or severe temporary harm (TJC, 2016). (A permanent loss of function related to the natural course of the patient's illness or underlying condition is not a Sentinel Event.) The State of Nevada defines a sentinel event as an event included in Appendix A of "Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report," published by the National Quality Forum (Nevada Revised Statutes NRS §439.830 – effective October 1, 2013).

**Sentinel Event Alert Gap Analysis:**

A model for prioritizing and addressing potential risks related to publish external sentinel or warning alerts.

**Unusual Occurrence:**

Any event or condition not consistent with the normal or usual operation of the hospital or department and which has the potential for causing patient or visitor injury or property damage.

**II. Policy**

The Board of Trustees delegates responsibility for oversight of the patient safety program to the Quality Care/Patient Safety Committee. The Quality Care/Patient Safety Committee monitors and evaluates the effectiveness of the Patient Safety Program and generates feedback and actions as appropriate. The Quality Care/Patient Safety Committee prepares a quarterly report to the Quality Care/Patient Safety Committee, Medical Executive Committee (MEC), and the Board of Trustees (BOT). The report includes at a minimum, occurrence or trending of patient safety indicators and actions taken in response to actual occurrences as well as proactive assessments of high-risk activities. The Environment of Care Committee oversees non-clinical safety related processes and system issues that affect patients, employees, and visitors in the environment of care.

Risk Management maintains the hospital-wide occurrence reporting system for patients, employees, and visitor occurrences and a referral system for hospital staff and

physicians to report potential claims. Risk Management in conjunction with Hospital Quality and Patient Safety Leaders investigate actual and potential safety risk within the organization. They also evaluate occurrences to identify those that may require immediate follow up actions or meet the Sentinel Event, the Safe Medical Device Act, or regulatory agency reporting criteria, including CMS, FDA, OSHA, State of Nevada DHHS, or Joint Commission. Notification is made to Administration, Risk Management, appropriate regulatory and accrediting agencies, equipment manufacturers and other appropriate individuals as necessary.

The Organization ensures timely coordination and dissemination of reporting and data management of patient safety information at the appropriate medical staff/organizational committees for review and discussion.

### **III. Culture of Safety**

Southern Hills Hospital is committed to creating a culture of safety by designing or redesigning systems and processes geared to prevent, detect, and minimize the hazards and likelihood of error. Southern Hills Hospital is focused on prevention, not blaming individuals. Patient safety events are viewed as an opportunity to learn. The Hospital believes in balancing the organization's accountability and the individual's accountability for assuring safe practices and a safe environment to care for patients.

### **IV. Structure, Roles and Responsibilities**

The philosophy guiding the promotion of a culture of patient safety is accountability. To achieve a culture of patient safety the following accountabilities are expected at Southern Hills Hospital:

| <b>Role</b>                                                         | <b>Accountability</b>                                    | <b>Specific Tasks</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Board of Trustees, with Senior Leadership                           | Set goals, monitor performance & require accountability. | <ul style="list-style-type: none"> <li>• Receive regular and thorough reports on patient safety risks, hazards and progress towards performance improvement objectives from the MEC and Patient Safety Committee.</li> <li>• Receive regular and thorough briefings regarding the results of culture measurement and performance improvement initiatives</li> <li>• Require multi-cause analysis of errors that lead to injury.</li> <li>• Set performance improvement goals for safety improvement.</li> <li>• Hold hospital leaders accountable for achieving the integrated patient safety agenda.</li> <li>• Receive systematic and regular assessment of resource and budget allocations to key systems (patient safety systems, human resources, quality systems, technology) related to the patient safety agenda.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                              |
| Administrative (CEO, COO, CNO, VP's, Directors, & Physician Leaders | Set the agenda for the rest of the team                  | <ul style="list-style-type: none"> <li>• Ensure that an integrated patient safety program is implemented throughout the hospital.</li> <li>• Set performance improvement priorities and identify how the hospital adjusts priorities in response to unusual or urgent events.</li> <li>• Allocate adequate resources for measuring, assessing and improving the hospital's performance and improving patient safety.</li> <li>• Measure and assess the effectiveness of the performance improvement and safety improvement activities.</li> <li>• Monitor implementation for of corrective action of patient safety events.</li> <li>• Ensure remedial activities, identified through analysis of reported patient safety events, are implemented, effective, and do not cause unintended adverse consequences.</li> <li>• Develop a proactive approach to reducing errors.</li> <li>• Encourage an environment of openness &amp; collaboration.</li> <li>• Support a dialogue about outcomes between patients and clinicians including systems to obtain direct feedback from patients regarding performance of the organization</li> <li>• Educate staff about safety.</li> <li>• Support staff and lead by example.</li> </ul> |

| <b>Role</b>            | <b>Accountability</b>                                                           | <b>Specific Tasks</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient Safety Officer | Lead patient safety initiatives with the medical staff and organizational staff | <ul style="list-style-type: none"> <li>• Lead an integrated patient safety program.</li> <li>• Serve as the primary point of contact for questions about patient safety, and coordinate patient safety for education and deployment of system changes.</li> <li>• Execute performance improvement priorities and adjusts priorities in response to unusual or urgent events.</li> <li>• Assure effectiveness in measuring, assessing and improving the hospital's performance and improving patient safety.</li> <li>• Lead a proactive approach to reducing errors and make recommendation to reduce patient safety events.</li> <li>• Lead in an environment of openness &amp; collaboration.</li> <li>• Assure dialogue about patient safety issues occurs effectively between patients and clinicians.</li> <li>• Report progress regularly, and educate about patient safety</li> <li>• Support staff and lead by example.</li> </ul> |
| Quality Coordinators   | Day to day coordination and facilitation of safety initiatives                  | <ul style="list-style-type: none"> <li>• Implement operational aspects of the patient safety program throughout the hospital.</li> <li>• Implement proactive patient safety management that assures immediate, appropriate response to unusual or urgent events.</li> <li>• Participate in measuring, assessing and improving the hospital's performance and improving patient safety.</li> <li>• Be accountable for patient safety initiatives and strengthening a culture of safety in day to day practice.</li> <li>• Support an environment of openness &amp; collaboration.</li> <li>• Support a dialogue about patient safety issues between patients and clinicians.</li> <li>• Report progress regularly, and educate about patient safety.</li> <li>• Support staff and lead by example.</li> </ul>                                                                                                                               |
| Pharmacists            | Ensure safe medication usage                                                    | <ul style="list-style-type: none"> <li>• Ensure that authoritative, up-to-date drug information is available in reference form in patient care areas and prescribers' offices.</li> <li>• Periodically examine all drug products stored in patient care areas and procedures on drug storage/distribution to patient care areas.</li> <li>• Minimize the need for nurses to calculate, manipulate, or mix medications.</li> <li>• Establish a pharmacy led interdisciplinary team to spearhead medication safety activities.</li> <li>• Provide leadership to develop safe medication delivery systems.</li> </ul>                                                                                                                                                                                                                                                                                                                         |



| <b>Role</b>                | <b>Accountability</b>            | <b>Specific Tasks</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|----------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Clinicians & Medical Staff | Monitor, report, & learn.        | <ul style="list-style-type: none"> <li>• Medical staff and other employee job descriptions and competency evaluations incorporate accountability for safety.</li> <li>• Medical staff &amp; employees participate in education on the importance of safety, surveillance, and expectations for reporting safety concerns, beginning with orientation.</li> <li>• Medical staff &amp; employees evaluations include an individual's contributions to safety for the organization.</li> <li>• Medical staff &amp; employees are positively acknowledged for disclosing errors, near-misses, and safety concerns.</li> <li>• Employees and physicians work collaboratively assuring responsibilities of the team to the patients are met, and noticing errors before they cause harm.</li> <li>• Participate in the facility reporting system for PS events, both actual and potential event.</li> </ul> |
| Patients/visitors          | Involved partners in prevention. | <ul style="list-style-type: none"> <li>• Inform doctors and nurses about medications they take, including prescriptions, over-the-counter drugs and dietary supplements.</li> <li>• Ask for written information about possible side effects.</li> <li>• Inform the doctors and nurses about allergies &amp; adverse reactions.</li> <li>• Ask a relative or friend to be an advocate.</li> <li>• Learn about their medical condition by asking their doctor, nurse, and other reliable sources.</li> <li>• Upon hospital discharge, ask doctors for an explanation of the treatment plan to be used at home.</li> <li>• Provide feedback regarding performance of the organization</li> <li>• Report safety concerns through the Patient Safety hotline and other venues available.</li> </ul>                                                                                                        |

## V. **Mechanisms for Coordination**

### **Southern Hills Hospital Patient Safety Committee**

The SHH Quality Care/Patient Safety Committee (QC/PSC) or equivalent is a multidisciplinary team involving department representatives that meets ~~not less than~~ monthly. The Quality Care/Patient Safety committee or equivalent committee, is comprised of various health care professionals including but not limited to physicians, nurses, pharmacists and administrators, and is chartered to oversee the implementation of the Hospital's Patient Safety Program. The Patient Safety Officer coordinates activities within the Patient Safety Program.

Structures that support the QC/PSC or equivalent works in conjunction with other safety committees, including but not limited to:

- Medication Safety



- Quality Council
- Environment of Care
- Falls Committee
- Infection Prevention Committee

The QC/PSC reviews and develops implementation strategies for the NPSG's. Strategies include assessing and developing a culture of patient safety, encouraging a non-punitive reporting environment, developing a best practice infrastructure to foster the design of safety into our systems, and monitoring of systems risks and improvements. The QC/PSC networks with other committees as appropriate per topic to gain consensus (e.g. Quality Care Committee, Infection Prevention, Pharmacy, other). Sentinel Event Alerts and other industry alerts are routed to the appropriate committee or teams to ensure evaluation of current care processes incorporate recommended changes.

The Director of Quality/Risk Management and the Patient Safety Officer reviews Sentinel Event Alerts, other industry alerts, compliance to The Joint Commission National Patient Safety Goals, State regulatory requirements, adverse events and potential adverse events that are deemed to be preventable, health care associated infections as defined by the CDC that are deemed to be preventable, and assures recommendations are integrated into processes. Additional resources such as national and local professional organizations/associations are monitored for changes in standards and potential risk events. Regular summary reports of progress are reported to the designated Quality Care Committee, Medical Executive Committee, and the Board of Trustees.

The QC/PSC reviews and approves plans to address key organizational concerns, such as Falls, Restraint Reduction, Patient/Family Education, Patient Mobility, Blood and Blood Components, Medication Safety, Adverse Drug Reactions (ADR's), Pressure Ulcer Prevalence, Health Care Associated Infections and Environmental issues updates. The QC/PSC recommends and provides direction for training on key initiatives and educational strategies related to patient safety.

## **VI. Communicating with Patients about Safety**

It is Southern Hills Hospital's philosophy that accountability for patient safety is imbedded in a collaborative relationship involving our Board of Trustees, administrative leadership, our medical staff, employees, patients and family.

Patient safety awareness information is posted in public areas throughout the hospital. This information contains basic strategies for patients to assist in assuring their safety. The admission and discharge patient information also contains information on the patient role in safety. Patient Guides are provided to in-patients upon admission, and includes strategies prevent untoward events such as falls, medication errors, and infections while in the hospital. Annually, Patient Safety Awareness Week activities are planned to educate and inform staff, patients and the community. The Southern Hills Hospital consumer web page also includes access to an electronic version of the Patient Guide.

Information and additional resources are provided to assure patient involvement in their care.

Patients or their families may contact the hospital to report patient safety concerns as well as to the State of Nevada Department of Health and Human Services or to the Joint Commission. The hospital's website and other patient materials include information on how to report issues internally as well as to the Joint Commission.

Patients are randomly selected to participate in completing the Patient Experience Survey after discharge, which include questions related to the patient safety experience. These results are reported to the hospital.

## **VII. Education**

### **1. Staff Education**

- General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety
- Specific Patient Safety Program training at orientation and annually thereafter will include:
  - An overview of the Patient Safety Program
  - Staff's role and responsibilities in the Patient Safety Program
  - Event reporting, including the events requiring reporting and the process for reporting events.
  - Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care;
  - Examples of specific job-related aspects of patient safety.

2. Physician Education - An overview of the Patient Safety Program is provided to physicians at time of initial appointment and periodically thereafter that describes the program, emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism and Culture of Safety processes.

3. Organizational Learning: Patient safety is everyone's responsibility. Everyone has a responsibility to report. By reporting concerns, it enables the organization to learn and improve processes, procedures, and systems.

## **VIII. Safety Improvement Activities**

### **Prioritization of Patient Safety Activities**

Prioritization elements are defined in the annual performance improvement plan and apply to patient safety initiatives. The QC/PSC annual goals are listed at the end of this plan and meet the prioritization elements.

### **Routine safety-related data collection analysis**

- Unusual Occurrence reporting (see SPAE Guidance Policy)
- Medication Error Reporting
- Infection Surveillance
- Culture of Patient Safety Survey
- Environmental Safety Rounds and Assessment
- Patient Experience Survey
- Leadership Walk-around and Tracers
- National Patient Safety Goal Dashboard
- Annual Leapfrog (NQF Safe Practices) Survey
- Sentinel Event Alert Compliance
- Institute for Safe medication Practices( ISMP) and other industry Alerts
- Employee feedback survey

### **Identification, reporting, and management of patient safety events**

1. To effectively improve processes and systems, health care providers should not be fearful of punishment or retribution for reporting mistakes.
2. An accessible multifaceted non-punitive, just culture reporting system exists .
3. Errors and accidents are tracked in an attempt to establish trends and patterns, to learn from them and prevent reoccurrence.
4. Healthcare providers participate in reporting and developing improved processes to effectively evaluate errors and near misses.
5. Reporting errors and near misses are a critical component of the Southern Hills Hospital Patient Safety Program.

The Meditech on-line incident reporting system is a tool for the documentation, investigation, and correction of patient safety issues as described in the organizational policy: The Patient Safety Director coordinates this process.

Organization or Medical Staff committees refer patient safety issues to the Patient Safety Officer for review at the PSC and corrective action.

### **NRS 439.877 – Monitoring and Compliance**

Nevada statute NRS 439.877 requires medical facilities to adopt patient safety checklists and patient safety policies. These patient safety checklists are protocols used to improve the outcomes of patients at the hospital to include:

1. Patient Discharge Process-Healthy Living (Meditech)
2. Patient Identification Process (Policy)
3. Patient room/environment sanitation and cleaning (Sodexo 7-Step Cleaning Process)
4. Additional patient safety checklists which may be appropriate to ensure the safety of patients in the facility. These include, but are not limited to the following:
  - a. Universal Protocol (Safe Procedural and Surgical Verification)
  - b. Central Line Insertion Bundle (Meditech)
  - c. Hand Hygiene (Audit Checklist)

Monitoring and oversight for compliance with these policies and checklists will be the ongoing responsibility of the Quality Care/Patient Safety Committee.

#### **NRS 439.865– Infection Control Program**

Nevada statute NRS 439.865 requires medical facilities have an infection control program to prevent and control infections within the medical facility, as well as an infection control policy. The Hospital's Infection Control Plan is attached as an addendum to the Patient Safety Plan and is reviewed annually. (See Appendix 2 – Infection Prevention and Control Plan)

#### **Proactive Risk Identification and Reduction:**

1. Opportunities for improvement regarding patient safety issues and hazardous conditions are identified through trending of actual or potential occurrences involving patients or visitors and/or evidence-based literature (e.g. The Joint Commission Sentinel Event Alerts).
  2. When an identified opportunity for improvement is identified, it is analyzed by the involved care providers according to level of severity, frequency of occurrence, potential for harm and liability.
  3. At least every 18 months, one high-risk or error-prone process is selected for Failure Mode Effect Analysis (FMEA) process. The underlying systems are examined and modified or redesigned to minimize the risk of the identified failure mode.
  4. Trending of adverse events, environmental safety issues, aggregate data collection, and review of intensive assessments are part of the identification and management of risks to safety and are used to prevent reoccurrences.
  5. Serious unusual occurrences and sentinel events are reviewed with determination made for intensive assessment and root cause analysis according to the SPAE policy.
  6. Near miss events are reviewed and root cause analysis conducted as deemed appropriate.
  7. Regular communication about patient safety and risk management is conducted with designated Quality Care Committee, Medical Executive Committee, and the Board of Trustees.
- Disclosure of an adverse event to a patient is in accordance with the SPAE policy.

### **IX. Reporting Patient Safety Results:**

#### **To the QC/PSC:**

The Quality Care/Patient Safety Committee reviews and recommends actions on the following reports:

- Audits and performance improvement activities on Patient Safety
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Culture of Patient Safety Survey
- Leapfrog Survey

**To organization staff and medical staff:**

Organizational staff receives patient safety results and information on:

- Culture of Safety Survey
- Patient experience survey results on patient safety components.
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Leapfrog Survey

**To executive leadership and Board of Trustees:**

The Board of Trustees and Executive Leadership receives periodic reports on:

- Culture of Safety Survey
- Leapfrog Survey
- Results of intensive analyses related to patient safety issues

**X. Annual Review**

The Patient Safety Program is reviewed annually and revised as necessary. It is submitted annually for review and approval by the Medical Executive Committee and the Board of Trustees.

**XI. References/Authority**

- The Joint Commission 2019 NPSG's
- HCA Patient Safety Organization PSO Operating Policy and Procedure  
Federal Register- Department of Health and Human Services 42 CFR Part 3  
Patient Safety and Quality Improvement

## Appendix One

### Strategic Priorities for 2019 - Goals

- ☐ Complete AHRQ Culture of Safety Survey with  $\geq 80\%$  participation
- ☐ Re-institute Non-punitive reporting program with recognition of a minimum of one employee; four appreciation opportunities throughout the year "Great Catch Award"
- ☐ Continue weekly Executive Leader Safety Briefs and Rounds
- ☐ Achieve 95% compliance with oxytocin process measures each quarter 4Q18 – 3Q19.
- ☐ Create facility-wide expansion and implementation plan for use of SBAR tool on all clinical high-risk areas and perform SBAR Hand-off Point Prevalence Audit
- ☐ 95% of leadership and staff complete viewership of "Hindsight" educational videography by end of 3Q19
- ☐ 95% of new hires from January 1-September 30, 2019 complete viewership of "Hindsight" educational videography by end of 3Q19
- ☐ Complete and submit a minimum of 4 Serious Event Analyses (SEAs) to the PSO
- ☐ Submit 4 case studies from completed SEAs to the PSO
- ☐ Submit 95% of all patient event and close call reports designated as PSWP within 60 days
- ☐ Reestablish Fall Monthly Committee starting 1Q19
- ☐ Participate in 80% of the Division-wide Patient Safety Table project
- ☐ Weekly Executive Leader Safety Briefs
- ☐ Implement Daily Nursing Safety Debriefs
- ☐ Attend Patient Safety Director Development Program
- ☐ Attend National Patient Safety Foundation Patient Safety Congress

# SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

## QUALITY AND PATIENT SAFETY PLAN 2020

**SNAMHS**

DATE: 02/27/2020  
VERSION: 01





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## Introduction

The SNAMHS patient safety program supports and promotes the mission, vision, and values of the Division of Public and Behavioral Health through protecting, promoting and improving the physical and behavioral health of the population that it serves and ensuring the highest obtainable level of safety for its staff, clients, visitors, and volunteers.

This plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of safety risks to patient, visitor and staff, promoting a blame free environment, as well as minimizing hazards, and integrating safety practices in the operations and services provided.

### **Patient Safety Committee/Program Rawson-Neal Hospital**

1650 Community College Dr.

Las Vegas, NV 89146

Cookie Gamiao, Interim Rawson-Neal Patient Safety Officer  
Director, Quality Assurance and Performance Improvement

[cgamiao@health.nv.gov](mailto:cgamiao@health.nv.gov)

702-486-4334



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## Commitment to Patient Safety

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SNAMHS is committed to safety by utilizing a patient safety program that enhances patient care delivery and prevent adverse outcomes through proactive risk assessments and integration of safety practices in everything that we do.

### Mission, Vision, and Values

In support of our mission, vision, and values, SNAMHS Patient Safety and Quality Improvement programs promote:

- Collaboration among staff members, physicians, leadership staff, and other healthcare providers to deliver integrated and comprehensive quality healthcare
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

## Scope and Purpose

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The scope of this Quality and Patient Safety Plan is organizational wide which includes but is not limited to

- Patient safety
- Visitor and volunteer safety
- Staff safety

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, near misses and adverse events, and revise as needed to better serve the patients and their families.

The core principles of this plan include:

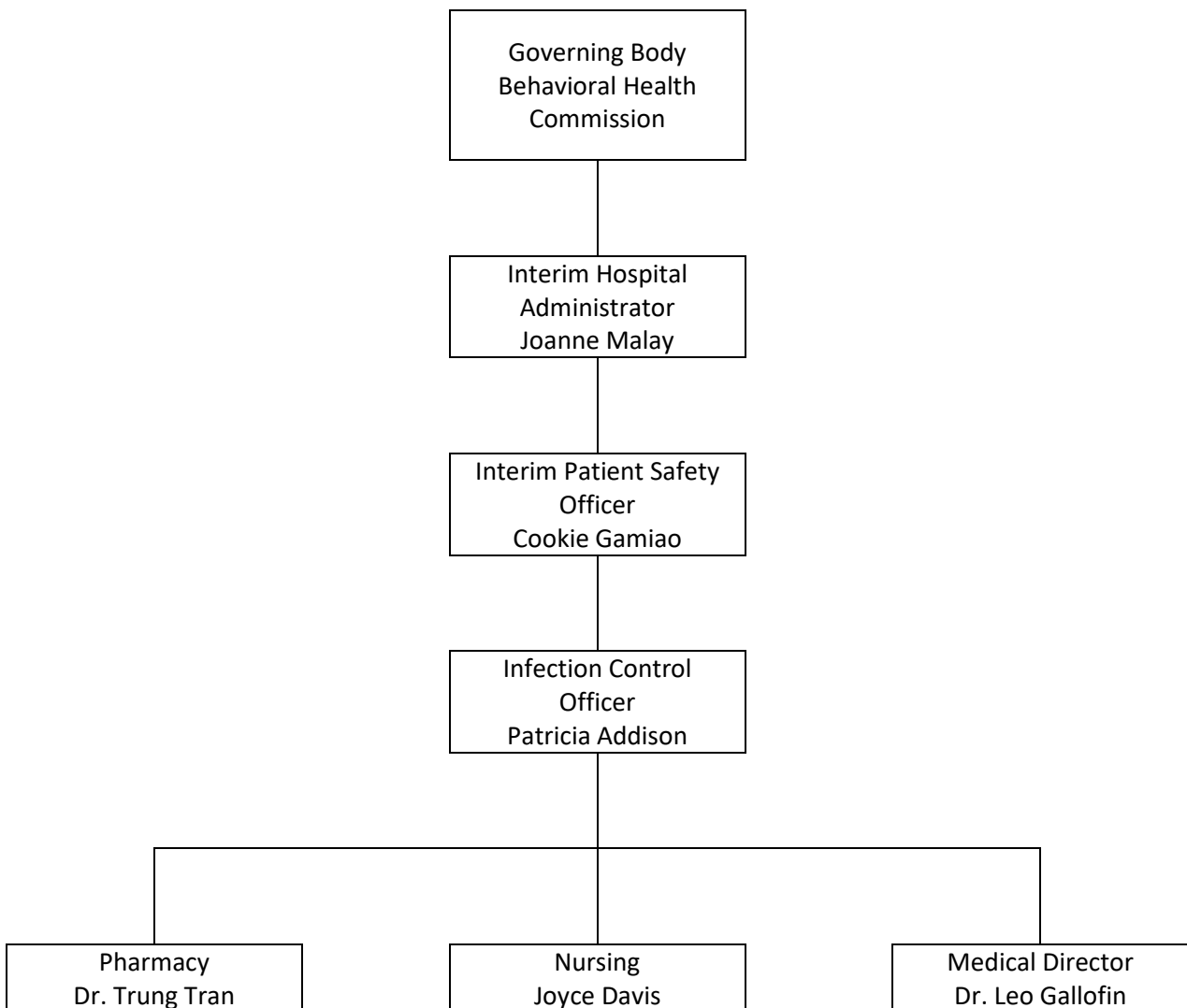
- All staff contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

## Roles and Responsibilities

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According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

### The Patient Safety Committee Organization



The roles and responsibilities are defined below.

### **Executive or Governing Body Staff Responsibilities**

- Provide vision and leadership to Patient Safety and Quality Improvement committees, and develop training programs that will enhance a safety culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

### **Roles and Responsibilities**

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.
- Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:
- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

### **Patient Safety Committee Responsibilities** (based on [NRS 439.875](#) and [NRS 439.877](#))

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Evaluate actions of the patient safety officer regarding all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:

- (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
- (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
- (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

**Patient Safety Officer Responsibilities** (based on [NRS 439.870](#))

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.
- Participate as a consultant to the RCA teams
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements

**Infection Control Officer Responsibilities** (based on [NRS 439.873](#))

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.
- Complete and submit the NSHN report to the state Registry and the CDC

The Patient Safety Committee will meet monthly to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.

- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

#### **RCA Facilitator Responsibilities**

- Organize and coordinate the RCA as well as facilitate the RCA process
- Identify team members and alert their supervisors, as well as the staffing department to provide coverage on their units or department
- Assemble and encourage a supportive and proactive team. Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.

#### **Root Cause Analysis (RCA) Team Responsibilities**

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

#### **An RCA meeting will meet as needed to accomplish the following:**

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- **Identify barriers and technical assistance needs for supporting the RCA efforts.**
  - A meeting agenda and minutes noting follow-up tasks will be kept.

## Objectives and Goals of the Quality and Patient Safety Plan

| Objective                                                                                                 | Goals                                                                                | Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Planned Completion Date | Responsible Party                                                                                                        |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------|
| Staff will perform hand hygiene on every patient, every time.<br><br>Staff will make handwashing a habit. | Increase annual hand hygiene compliance to 90% or higher. Current compliance is 87%. | <ul style="list-style-type: none"> <li>• Provide easy access to hand hygiene products.</li> <li>• Conduct observation, monitoring, and audit to better understand contributing factors to non-compliance.</li> <li>• Educate staff on proper compliance when failures are observed.</li> <li>• Educate staff on when to perform hand hygiene and proper handwashing technique.</li> <li>• Post informational posters and provide flyers on hand hygiene.</li> </ul> | Ongoing                 | Infection Control Nurse and Patient Safety Officer                                                                       |
| Objective                                                                                                 | Goals                                                                                | Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Planned Completion Date | Responsible Party                                                                                                        |
| Increase staff compliance for seasonal flu vaccines by 10% yearly. Current compliance rate is 74%         | 100 % staff compliance rates for Flu vaccines                                        | <ul style="list-style-type: none"> <li>• Determine root cause for low compliance rate</li> <li>• Promotion of strict policy enforcement and clear analogies for denials</li> <li>• Determine why supervisors are not actively involved in making sure their employees are compliant with flu requirements each season</li> <li>• Campaign and thoroughly educate staff, cooperate and individually who decline Flu vaccination. Enforce</li> </ul>                  | Ongoing                 | Infection Control<br><br>Infection Control<br><br>Infection Control<br><br>Infection Control<br><br>Administration/Chief |

|  |  |                                                               |  |                                     |
|--|--|---------------------------------------------------------------|--|-------------------------------------|
|  |  | flu masking policy for those who decline the flu vaccination. |  | Medical Officer/Director of Nursing |
|  |  |                                                               |  |                                     |

## Components and Methods

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Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.”

Rawson-Neal will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, which we will use to test the changes

-





## Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

**Root cause analysis and action plan framework table**, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

**5 Whys** technique will be used in Rawson-Neal to explore the cause and effect relationship underlay a problem. One can find the root causes by asking “why” no less than five times. This technique can be used individually or as a part of the fishbone diagram.

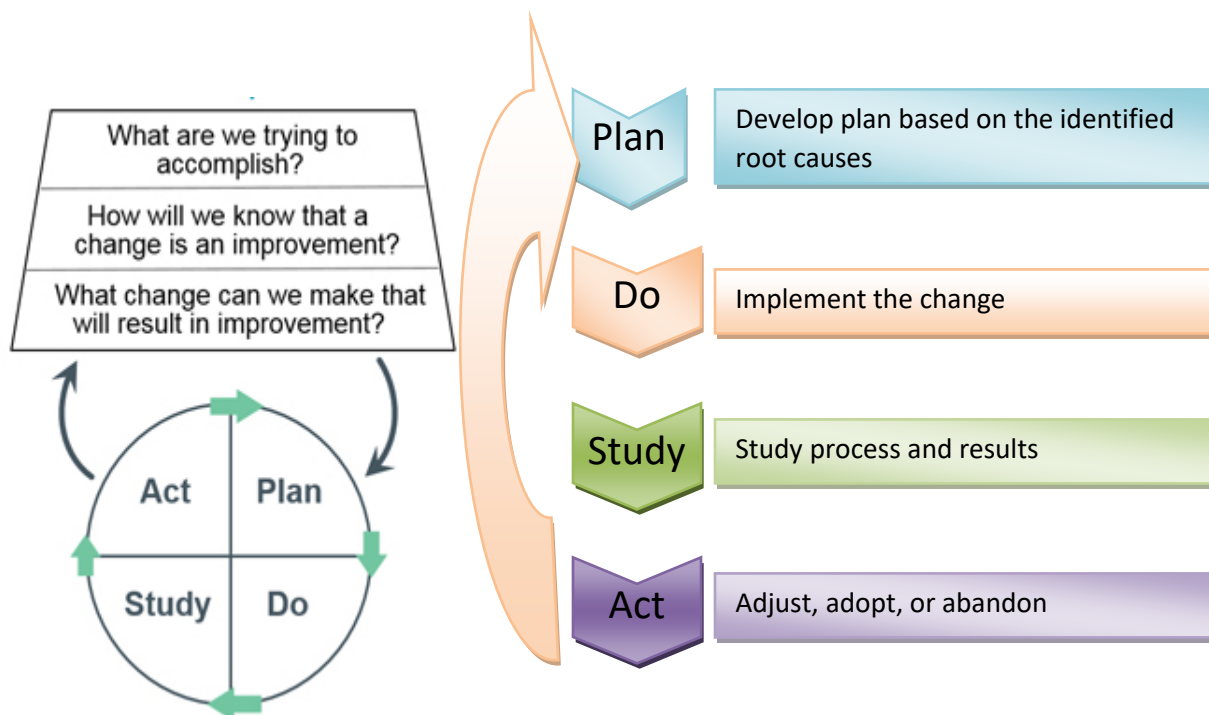
## Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, “why did this happen?” for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why’s technique also can be used to drill down the problem and find the root causes.

## Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes and answer the following questions.
  - What is the objective of the test?

- What are the steps for the test - who, what, when?
- How will you measure the impact of the test?
- What is your plan to collect the data needed?
- What do you predict will happen?
- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?
- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?
- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

## Data Collection and Reporting

Data should drive any quality and patient safety effort. SNAMHS is using Avatar for tracking the sentinel events, healthcare infection data and seclusion and restraint data.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission



## Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

| Monthly                                                                                                                                  | Quarterly                                                                                                                                                                                                                                                                 | Annually                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1) Sentinel event monthly report<br>2) Severity of infection report<br>3) RCA Report<br>4) Seclusion and Restraint events monthly report | 1) Sentinel event quarterly report<br>2) Review and evaluate the measurement to prevent and control infections<br>3) Review and evaluate the plans of correction for RCAs within each quarter<br>4) Review and evaluate data trending in seclusion and restraint episodes | 1) Yearly Quality and Patient Safety Plan update, due March 1, 2018<br>2) Yearly Sentinel Event Report, due March 1, 2018<br>2) Yearly AB280 report (Checklists and Policies reviewing and revising) due July 1, 2018 |

## Assessment of the Quality and Patient Safety Plan

Please see the Patient Safety Assessment Tool (PSAT) from the VA National Center for Patient Safety for your reference.

## Patient Safety Checklists and Patient Safety Policies

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By [NRS 439.865](#), the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.

- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on [NRS 439.865](#), the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E.**)

[http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)

<http://www.who.int/patientsafety/implementation/checklists/en/>

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F.**)

<https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>

## Approval of Patient Safety Plan

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According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

## Reference

- Root Cause Analysis Toolkit <http://www.health.state.mn.us/patientsafety/toolkit/>
- Quality and Service Improvement Tools  
[http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/plan\\_do\\_study\\_act.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html)
- CQI 101 An Introduction to Continuous Quality Improvement:  
<https://www.coursehero.com/file/13827355/CQI-Overviewppt/>
- Quality Improvement <http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/>
- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2  
[https://www.jointcommission.org/sentinel\\_event.aspx](https://www.jointcommission.org/sentinel_event.aspx)
- Hospital Policies <https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1>
- Checklists to Improve Patient Safety [http://www.hpoe.org/Reports-HPOE/CkLists\\_PatientSafety.pdf](http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf)
- Patient Safety Checklists <http://www.who.int/patientsafety/implementation/checklists/en/>
- Minutes of the Meeting of the Quality and Patient Safety Committee  
<http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf>
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>

## Appendix A: Terms and Definitions

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**Patient Safety:** The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”  
[http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick\\_110.pdf](http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf)

**Sentinel event** ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

**Facility-Associated Infection:** ([NRS 439.802](#))

“Facility-acquired infection” means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to [NRS 439.890](#).

(Added to NRS by [2005, 599](#); A [2009, 553](#))



**Medical facility** ([NRS 439.805](#))

“Medical facility” means:

- A hospital, as that term is defined in [NRS 449.012](#) and [449.0151](#);
- An obstetric center, as that term is defined in [NRS 449.0151](#) and [449.0155](#);
- A surgical center for ambulatory patients, as that term is defined in [NRS 449.0151](#) and [449.019](#); and
- An independent center for emergency medical care, as that term is defined in [NRS 449.013](#) and [449.0151](#).

(Added to NRS by [2002 Special Session, 13](#))

**Near miss:** An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Mandatory reporting:** Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985; 254(6):796-800.)

**Risk:** Possibility of loss or injury. (Merriam-Webster’s Online Dictionary, Risk, Available at <http://www.merriamwebster.com/dictionary/risk>. Last Accessed August 2009.)

**Preventable event:** Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

**Catheter Associated Urinary Tract Infection (CAUTI):** A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at [http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN\\_Manual\\_PatientSafetyProtocol\\_CUR\\_RENT\\_b.pdf](http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR_RENT_b.pdf).)

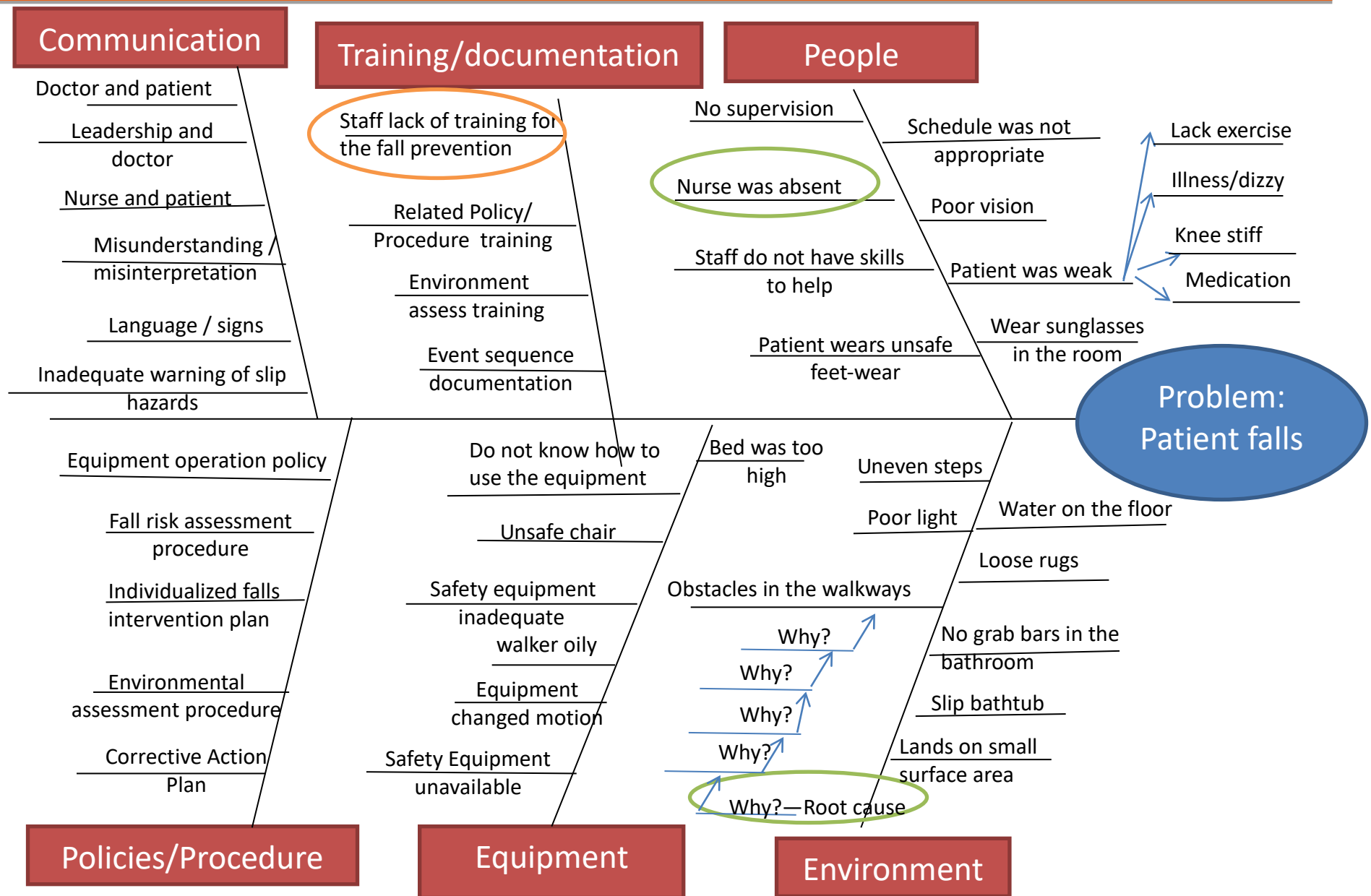
**Central Line Associated Bloodstream Infections (CLABSI):** Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

## Appendix B: Patient Safety Goals

| OBJECTIVE:                                                                                                                                                          | GOAL:                                                                                                                                                                                                                                                                                                        | Q3 2014                                                                                                                                                         | Q4 2014                                                                                                                                                                                                                                              | Q1 2015                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <b>ACTION PLAN:</b>                                                                                                                                                 |                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                 |                                                                                                                                                                                                                                                      |                                                                               |
| <b>1. Create Systems</b> that anticipate errors & either prevent or catch them before they cause harm.                                                              | a. Enhance retrospective chart review process.<br>b. Establish an automated surveillance process.<br>c. Conduct a proactive risk assessment in a high risk area.                                                                                                                                             |                                                                                                                                                                 | Complete an in-depth analysis of risk point utilizing the methods of FMEA.                                                                                                                                                                           | Implement Trigger Tools.<br>Develop automated surveillance reports in Cerner. |
| <b>2. Establish Structures</b> for reporting and a process for managing reports in the event reporting system.                                                      | a. Implement new electronic Voluntary Reporting System & participate in Patient Safety Organization.<br>b. Develop a structure to educate employees system-wide of the process for reporting hazards, errors and adverse events.<br>c. Establish a process for providing feedback regarding reported events. | Implemented e-MERS & PSO with UHC.<br>Create process for reviewing & closing reports in e-MERS.<br>Create process for communicating outcome of reported events. | Increase number of events reported by 10%.                                                                                                                                                                                                           |                                                                               |
| <b>3. Develop a Culture of Safety</b> where providers feel safe and supported when they report medical errors or near misses & voice concerns about patient safety. | a. Provide education on patient safety plan that emphasizes importance of blending a systems focus with appropriate individual accountability.<br>b. Establish a recognition program that rewards safe practices.<br>c. Improve overall perceptions of safety as measured by the Culture of Safety Survey.   |                                                                                                                                                                 | Educate Medical staff, Hospital Wide Oversight & the Quality Committees on the objectives and goals of the patient safety plan.<br>Include patient safety presentation in monthly New Employee Orientation.<br>Develop 'Great Catch' awards program. | Re-evaluate culture of safety and develop action plan.                        |
| <b>4. Establish Safety Priorities &amp; Targets.</b>                                                                                                                | a. Develop Patient Safety Dashboard that includes national measures and benchmarks.<br>b. Facilitate the development of action plans associated with measures not meeting benchmarks.<br>c. Assess and improve processes related to hand-off, transition and communication                                   | Complete 2014 Leapfrog Safety Survey.<br>Develop method to track & report departmental progress and compliance of RCA action plans.                             | Present Patient Safety Dashboard monthly to Hospital Wide Oversight Committee.<br>Establish & implement a plan to improve performance of each leap.                                                                                                  |                                                                               |
| <b>5. Charter Safety Programs</b> through teams, workgroups or projects.                                                                                            | a. Coordinate Improvement Efforts in order to ensure that capital, people, facilities & technologies are matched to strategic priorities for safe practices.<br>b. Reduce and eliminate variation in care.                                                                                                   |                                                                                                                                                                 | Establish Patient Safety Council.<br>Establish workgroups focused on medication safety, reducing patient falls & hospital acquired pressure ulcers.<br>Revise or develop policies, procedures and protocols.                                         |                                                                               |

Reference: Patient Safety Plan and Its Applicable Goals. 2014. Cook County Health and Hospitals System.

## Appendix C: Fishbone Diagram



## Appendix D-1: PDSA Worksheet

### PDSA Worksheet

|                                                                                 |  |        |  |
|---------------------------------------------------------------------------------|--|--------|--|
| Topic:                                                                          |  |        |  |
| Person Completing Worksheet:                                                    |  | Date:  |  |
| Telephone/ Email:                                                               |  | Cycle: |  |
| Patient Safety Committee Members                                                |  |        |  |
| CEOs/CFOs                                                                       |  |        |  |
| Patient Safety Officer                                                          |  |        |  |
| Infection Control Officer                                                       |  |        |  |
| Other Medical Staff                                                             |  |        |  |
| Other team members                                                              |  |        |  |
| <b>Aim:</b> (Describe the overall SMART goal that your team wishes to achieve.) |  |        |  |
|                                                                                 |  |        |  |
| <b>Plan:</b>                                                                    |  |        |  |
| 1. List the tasks needed to set up this test of change.                         |  |        |  |
|                                                                                 |  |        |  |
| 2. Predict what will happen when the test is carried out.                       |  |        |  |
|                                                                                 |  |        |  |

3. List the steps to develop the test-who, what, and when.

| Steps | By Whom | By When | Desired Outcome |
|-------|---------|---------|-----------------|
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |
|       |         |         |                 |

**Do:** (Describe what actually happened when you ran your test, including any problems and unexpected findings.)

**Study:** (Describe what you learned and did you meet your measurement goal?)

Did you meet your measurement goal? Explain.

**Summarize what was learned: success, failure, unintended consequences, etc.**

**Act:** (Describe what you concluded from this cycle.)

Based on what was learned, please indicate what action will be considered.

**Describe what modifications to the plan will be made for the next cycle based on what you learned.**

☐ Adapt: modify changes and repeat PDSA Cycle

☐ Adopt: expanding changes throughout organization

☐ Abandon: change approach and repeat PDSA cycle

## Specialty Surgery Center

### **SAFETY MANAGEMENT PROGRAM 2020**

#### **POLICY AND PROCEDURE**

##### **Policy:**

It is the policy of Specialty Surgery Center to provide a physical environment free of physical hazards for the patients, employees and visitors. In addition, monitor those activities that have the potential to minimize the possibility or risk associated with those physical hazards. The Governing Board has final oversight of the safety program/plan

##### **PURPOSE:**

The purpose of the safety management program is to establish, organize, implement, monitor, and evaluate an effective program designed to provide a physical environment free of hazards and to manage staff activities to reduce the risk of human injury. Safety is an ongoing process and each employee and medical staff provider should be constantly aware of providing a safe environment for themselves, patients and visitors.

##### **GOALS AND OBJECTIVES**

The objectives and goals of the safety management program are to reduce and eliminate unnecessary hazards within the facility by:

1. Identification of individuals who will be responsible for the overall coordination, direction, and monitoring of safety activities within the Center.
2. Establishing a procedure whereby any Center employee or medical staff member will be encouraged to identify and present problems, deficiencies, and ideas for review and analysis in an effort to improve overall safety at Center.
3. Assuring the various problems and opportunities to improve safety are objectively assessed and that performance indicators designed to achieve an optimum level of safety are monitored.
4. Assuring that the safety activities are properly documented to indicate findings, conclusion, actions, recommendations, and evaluation of the effectiveness of the action that was taken.
5. Providing for a method of communication that allows for effective collection and dissemination of information relating to safety activities.
6. Establishing and maintaining an ongoing mechanism for monitoring the resources necessary to ensure the safety of the patients, staff, visitors, building, grounds, and internal physical systems

##### **AUTHORITY AND RESPONSIBILITY**

The Governing Body shall maintain ultimate responsibility for the oversight and effectiveness of the safety management program and shall strive to assure a safe environment for patients, staff and visitors. The Governing Body, through Administration, Risk Manager, and managers shall provide whatever administrative assistance that is reasonably necessary to support and facilitate the implementation of ongoing operation of this effort.

The Governing Body has appointed the Safety Officer. His/her role includes:

1. Oversight of the implementation and maintenance of safety practices at the Center.
2. Proactive with ergonomics in the workplace.
3. Integration of safety as part of the Center wide Quality and Risk Plans.
4. Assures investigation and follow through of any unsafe practices identified.
5. Work with managers to ensure ongoing education of employees through staff inservice, emergency (mock) drills, online training, and new employee orientation.
6. Surveillance and audits to identify areas of opportunity.

The Center, in conjunction with the building management, will maintain a safe building and grounds.

1. Routine maintenance is provided by building management.
2. Utilities and emergency backup systems are checked routinely.
3. The Centers should report any unsafe conditions in the building or grounds immediately to the management.
4. The Center will conduct periodic safety rounds to check for potential hazardous risks. Risks are corrected as soon as possible.

### **SCOPE OF SAFETY MANAGEMENT PROGRAM**

The safety activities for the Center are a function of all employees, medical staff, the Medical Executive Committee (MEC), and Governing Body. The following delineates the scope of service of the safety management program.

1. All areas of the Center. This includes:
  - a) Clinical areas
  - b) Public access areas
  - c) Employee areas
  - d) Outside sidewalks and grounds
  - e) Mechanical equipment areas
2. Maintenance of a safe environment
3. Life Safety
4. Equipment management
5. Utilities management
6. Hazardous Materials management
7. Emergency preparedness
8. Security management
9. Training and Education
10. Quality Improvement activities

### **COMPONENTS OF THE PROGRAM/PLAN**

The safety management program shall contain the following components and related policies:

1. **Safety Management**, which includes:
  - a) General safety policies
  - b) Fall Risk assessment
  - c) Appointment of a Safety Officer
  - d) Staff Education and training

- e) QI/Risk/Safety/Infection Control Committee
- 2. **Life Safety Management**, which includes:
  - a) Buildings
  - b) Grounds
  - c) Fire warning and safety systems
- 3. **Equipment Management**, which includes:
  - a) Patient care equipment
  - b) User errors/equipment failures
  - c) Product/equipment alerts/recall
  - d) Electrically powered equipment
- 4. **Utilities Management**, which includes:
  - a) Life support systems
  - b) Infection control systems
  - c) Communications systems
  - d) Equipment support systems
  - e) Utilities outage/failure
- 5. **Hazardous Materials**:
  - a) Selection
  - b) Training
  - c) Inventory
  - d) SDS
- 6. **Emergency preparedness**:
  - a) Management of disasters, internal and external
  - b) Involvement of the Center in community disaster (drills and actual)
- 7. **Security Management**
  - a) Variance reporting
  - b) Security risk assessment
- 8. **Radiation Management**
  - a. Dosimetry monitoring
  - b. Radiation audits
  - c. C-arm logs to assure < 20 individual exposure time

## **MONITORING AND EVALUATION**

There is ongoing monitoring of the safety program to ensure compliance with all regulatory agencies and Center policies. Results of the monitoring activities are reported to Administration, QI Committee, MEC and the Governing Body. The staff are informed through departmental meetings and staff in-services.

### **1. Data Resources Used for Monitoring**

- a) Quality/Risk Monitors
- b) Variance reports
- c) Outside regulating agencies reports ( AAAHC,TJC, QRS, CMS, State, Fire Marshall, OSHA etc)
- d) Preventive maintenance reports (from engineering and biomed)
- e) Surveillance rounds (IFC, Safety, Radiation etc.)
- f) Fire drill critiques



- g) Disaster drill critiques
- h) Claims data/Probable Claims Reports

## **2. Areas of Improvement**

Data information will be evaluated to determine if there are any problems or opportunities for improvements in the service. The source of the problem will be analyzed to determine if the problem occurred because of:

- a) Insufficient knowledge
- b) Problems in the system
- c) Poor performance due to lack of conformity to policy
- d) Other

## **3. Corrective Action**

Appropriate actions will be implemented to eliminate or alleviate the identified problems. Actions may be taken by the manager, Risk Manager, Administrator, or QI Committee. Actions may include, but are not limited to:

- a) Education/training
- b) Revision of policies and procedures or implementation of new policies
- c) Staffing adjustments
- d) Change in equipment, vendors, repair services, etc.
- e) Counseling/guidance

## **4. Follow-up and Evaluation**

- a) Follow-up and evaluation of the corrective actions will be done through the Quality Improvement/Risk Management Committee.
- c) Based on the evaluation by the Quality Improvement/Risk Management Committee, the need for further monitoring or additional corrective action will be determined.
- d) All evaluations of monitoring will be reflected in the Quality Improvement Committee, MEC, and Governing Body minutes.

## **5. Safety Monitoring and Evaluation Reporting**

Results of monitoring, evaluation, corrective actions and evaluation of same shall be communicated to:

- a) Center Quality Improvement/Risk Management Committee (Quarterly)
  - b) Medical Executive Committee (Quarterly)
  - c) Governing Body (Quarterly)
  - d) Managers (monthly or as appropriate for dissemination to Center employees)
- Findings and change in policies and processes are communicated to the staff through staff meetings or other desired method of communication.

## **POLICIES**

The Center has policies and procedures that promote safety as a priority. These policies and procedures are developed in accordance with regulatory standards and current trends in healthcare. These policies include, but are not limited to...

1. Fall Risk Assessment
2. Product Recalls
3. Medication Administration and Control policies
4. Exposure Control Plan
5. Sharps Prevention
6. Infection Control Plan

7. Equipment inventory and maintenance policies
8. Variance Reporting
9. Employee response grids to systems failure
10. Emergency Preparedness Plans- Bioterrorism, Weather, Evacuation, Fire Safety, Bomb Threats, etc.
11. Emergency Procedures- Respiratory Arrest, Malignant Hyperthermia. Child Abduction, Chemical Spills etc.
12. Procedures for Incapacitated and/or Impaired Healthcare provider

#### **SAFETY MANAGEMENT PROGRAM APPRAISAL**

The program is reviewed at least annually or as indicated by other activities or survey findings.

**References:** AAAHC, JCAH, CMS, OSHA standards. HCALife Safety program

|                                                          |                           |
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| Approved: 1.30.19<br>1.7.2020                            | Revised:                  |

## **PURPOSE AND MISSION:**

The Quality Assessment and Performance Improvement (QAPI) Program at Stonecreek Surgery Center involves an unrelenting and broad based search for improved ways of delivering service, practice and governance.

Our goal is to deliver superior quality patient care and produce optimal patient outcomes, through the efficient management of our material and human resources. A variety of processes are incorporated in this QAPI Program in order to achieve this goal.

## **COMMITMENT TO PERFORMANCE:**

The Governing Body, administration, management, employees and medical staff of Stonecreek Surgery Center are committed to continually seeking ways to improve the quality of services provided. It is believed, improvement in performance is possible and as an organization, we will strive to meet or exceed all reasonable expectations at a cost that represents value to the client. We believe we can improve overall performance by taking actions that result in measurable change, in order to positively impact patient outcomes.

## **GOALS:**

The primary goals of the Quality Assessment and Performance Improvement Program are to continually and systematically plan, design, measure, assess and improve performance of critical focus areas, improve healthcare outcomes, and reduce and prevent medical/health care errors. To achieve these goals, the plan strives to:

- Incorporate quality planning throughout the facility.
- Provide a systematic mechanism for the facility staff to function collaboratively in their efforts toward performance improvement, providing feedback and learning throughout the facility.
- Provide for a comprehensive program that assures the facility designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses and improves its performance to achieve optimal patient health outcomes in a collaborative and interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of the patients and their families, staff and others. Process design contains the following focus elements:

- Consistency with the organization's mission, vision, values, goals and objectives, and plans
  - Meets the needs of individuals served, staff and others
  - Use of clinically sound and current data sources (for instance, use of practice guidelines, information from relevant literature and clinical standards)
  - Is based upon sound business practices
  - Incorporates available information from internal sources and other organizations about the occurrence of medical errors and sentinel events to reduce the risk of similar events in this institution
  - Utilizes the results of performance improvement, patient safety and risk reduction activities
- The facility incorporates information related to these elements, when available and relevant, in the design or redesign of processes, functions or services.
  - Assure that the improvement process is facility wide, monitoring, assessing and evaluating the quality and appropriateness of patient care, patient safety practices and clinical performance to resolve identified problems and improve performance. Appropriate reporting of information to the Governing Body to provide the leaders with the information it needs in fulfilling its responsibility for the quality of patient care and safety is a required mandate of this plan.
  - The status of identified problems is tracked to assure improvement or problem resolution.
  - Information and the findings of discrete performance improvement activities are used to detect trends, patterns of performance or potential problems that affect more than one department/service.
  - The objectives, scope, organization and mechanisms for overseeing the effectiveness of monitoring, assessing, evaluation and problem-solving activities in the performance improvement program are evaluated annually and revised as necessary.

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- Treatment and services affecting the health and safety of patients are identified. Included are those that occur frequently or affect large numbers of patients; place patients at risk of serious consequences or deprivation of substantial benefit if care is not provided correctly or not provided when indicated; or care provided is not indicated, or those tending to produce problems for patients, their families or staff.

### **SCOPE OF ACTIVITIES:**

The scope of the Quality Assessment and Performance Improvement Program includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided and patient safety practices. The program consists of these focus components:

- performance improvement
- patient safety
- quality assessment/improvement
- quality control activities

Collaborative and specific indicators of both key processes and outcomes of care are designed, measured and assessed by all appropriate departments/services and disciplines of the facility in an effort to improve patient safety and organizational performance. These indicators are objective, measurable, based on current knowledge and experience and are structured to produce statistically valid, data driven, performance measures of care provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time.

The scope of the organizational performance improvement program includes performance of the following medical staff functions:

- The monitoring, assessment and evaluation of the patient care and the clinical performance of all individuals with clinical privileges. At quarterly meetings of the Medical Advisory Committee, patient care and quality control activities are monitored, assessed and evaluated and all findings and data gathered that impact patient care and safety will be reviewed, assessed and evaluated:
  - Operative/Invasive Procedure Monitoring
  - Medication Management
  - Information Management
  - Pharmacy and Therapeutics

- Safety Management
- Risk Management
- Infection Control
- Peer Review
- Utilization Management
- Assessment of the performance of the following patient care and organizational functions are included:
  - 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
- Relevant findings from performance improvement activities performed are considered part of:
  - Reappraisal/reappointment of medical staff members
  - The renewal or revision of the clinical privileges of individuals who practice independently
  - The mechanism used to appraise the competence of all those individuals not permitted to practice independently

|                                                          |                           |
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## ORGANIZATION:

To achieve fulfillment of the objectives, goals and scope of the Quality Assessment and Performance Improvement Program, the organizational structure of the program is designed to facilitate an effective system of monitoring, assessment and evaluation of the care and services provided throughout the facility.

- The Governing Body is responsible for the quality of patient care provided.
  - The Governing Body requires the medical staff to implement and report on the activities and the mechanisms for monitoring, assessing and evaluating patient safety practices and the quality of patient care, for identifying and resolving problems and for identifying opportunities to improve patient care and services or performance throughout the facility. This process addresses those departments/disciplines that have direct or indirect affect on patient care, including management, administrative functions and contracted services.
  - The Governing Body requires the detail and frequency of data collection for all indicators and performance processes as outlined in this program. The Governing Body further delegates the authority for data analysis, evaluation, action determination, implementation and outcome evaluation to the individuals and committees listed in this program.
  - The Governing Body provides for resources and support systems for the performance improvement functions and risk management functions related to patient care and safety.
  - The Governing Body has a responsibility to evaluate the effectiveness of the performance improvement activities performed throughout the facility and the Quality Assessment and Performance Improvement Program as a whole.
- With **authority** delegated by the Governing Body, the medical staff strives to improve and assure the provision of quality patient care through the monitoring, assessment and evaluation of performance measurement and outcome.
  - The medical staff provides effective mechanisms to monitor, assess and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the medical staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

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- The Medical Advisory Committee delegates the oversight responsibility for performance improvement activity monitoring, assessment and evaluation of patient care services provided throughout the facility to the Quality Assessment and Performance Improvement Coordinator.
- The QAPI Coordinator may form small teams as necessary to perform the QAPI processes required for improving processes involved in patient care and organizational functions. Small team reporting is through the QAPI Coordinator to the Medical Advisory Committee, as appropriate.
  - The QAPI Coordinator will be responsible for 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 Medical Advisory Committee to prioritize organizational patient safety activity efforts.
  - The QAPI Coordinator will be responsible for providing the Governing Body with a written report regarding the results of proactive risk assessments, lessons learned from root cause analyses, all systems or process failures, the number and type of sentinel events, whether patients and the families were informed of sentinel events, and all actions taken to improve safety.

## **METHODOLOGY:**

The **Plan, Do, Check, Act (PDCA)** methodology is utilized to plan, design, measure, assess and improve functions and processes related to patient care and safety throughout the facility.

### Plan:

- Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated, and/or have been or likely to be problem prone.
- Performance measures are based on current knowledge and clinical experience.
- Data will be collected from internal sources (staff) and external sources (patients, referral sources, etc.). The following data sources will be reviewed for use in the development of performance measures:



|                                                          |                           |
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- Staff opinions and needs
- Staff perceptions of risks to patients and suggestions for improving patient safety
- Staff willingness to report medical/health care errors
- Outcomes of processes or services, including adverse events
- Performance measures from facility approved internal and external databases
- Infection control surveillance and reporting
- Patient and family perceptions of care, treatment and services (satisfaction surveys)
  - Data collected includes the specific need and expectations of the patients
  - Patient's perceptions on how well the facility meets these needs and expectations
  - Patient suggestions regarding improvement of patient safety
  - Patient's perceptions of effectiveness of pain management
- Risk management
- Utilization management
- Quality control
- Customer demographics and diagnoses
- Performance measures for processes that are known to jeopardize the safety of patients or associated with sentinel events will be routinely monitored. At a minimum performance measures related to the following processes, as appropriate to care and services provided, are monitored with the approval and at the suggested frequency of the Performance Improvement Committee:
  - Management of hazardous conditions
  - Medication management

- Operative and other invasive procedures
- Restraint use
- Outcomes related to resuscitation
- Staffing effectiveness
- Appropriateness of pain management
- Care or services to high-risk populations
- National patient safety goals
- Benchmarks or thresholds that trigger intensive assessment and evaluation are established. Undesirable patterns or trends in performance are analyzed for all of the above. However, an in-depth analysis is conducted for the following when the levels of performance, patterns or trends vary substantially from those expected:
  - All serious adverse drug events
  - All significant medication errors
  - All major discrepancies between preoperative and postoperative (including pathologic) diagnoses
  - Adverse events or patterns of adverse events during moderate or deep sedation and anesthesia use
  - Hazardous conditions

Do:

- Data is collected to determine:
  - Whether design specifications for new processes were met
  - The level of performance and stability of existing processes
  - Priorities for possible improvement of existing processes

|                                                          |                           |
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Check:

- Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas.

Act:

- Take actions to correct identified problem areas or improve performance.
- Evaluate the effectiveness of the actions taken and document the improvement in care.
- Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services.
- Information Management:
  - Performance improvement activities throughout the facility are dependent upon the management of information function. This function is performed to obtain, manage and use information to enhance and improve individual and organizational performance in effective communication, patient care and safety, governance, management and support processes. The quality of the medical record is reviewed for accuracy, timeliness, completeness, clinical pertinence and legibility.
- Performance Improvement Oversight Responsibility:
  - The outcome of review performed for all facility functions will be submitted to the Medical Advisory Committee and Governing Body for their approval.
  - The results of performance improvement activities and organizational function review performed throughout the facility will be considered in the decision process for determination of educational programs for medical staff and facility personnel and other individuals that this education may benefit.
  - Relevant findings from the outcome of performance improvement activities performed to monitor, assess and evaluate the patient safety practices, and patient care and services provided by individuals who are not subject to the medical staff privilege delineation process, will be considered as part of clinical competence evaluations. A report in summary format of the findings of clinical competence evaluations for these individuals will be submitted to the Governing Body for information and evaluation purposes.

|                                                          |                           |
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## **REPORTING FORMAT:**

The findings, conclusions, recommendations, actions taken to improve performance and the results of actions taken are documented and reported through established channels.

- Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, will be reported to the Medical Advisory Committee on a quarterly basis.
- The QAPI Coordinator will report to the Medical Advisory Committee on an as needed basis, when significant issues of quality or safety of patient care and services are identified.
- The Medical Advisory Committee will provide the Governing Body with a report of the relevant findings from all performance improvement activities on a quarterly basis.

## **ANNUAL EVALUATION AND APPROVAL:**

To assure that the appropriate approach to planning processes of improvement; setting priorities for improvement; assessing performance systematically; implementing improvement activities on the basis of assessment; and maintaining achieved improvements, the facility Quality Assessment and Performance Improvement Program is evaluated for effectiveness at least annually and revised as necessary.

The QAPI Program Assessment Guide will be used for this evaluation and the findings will be reported at the MAC/Governing Body meeting annually.

## **CONFIDENTIALITY:**

All information related to performance improvement activities performed by the medical staff or facility personnel in accordance with this plan are confidential.

- Confidential information may include, but is not limited to, the medical staff committee minutes, QAPI reports, electronic data gathering and reporting, untoward incident reporting and clinical profiling.
- Some information may be disseminated on a "need to know basis" as required by agencies such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proved a "need to know basis" as approved by the Medical Advisory Committee and/or the Governing Body.

**SUMMERLIN HOSPITAL MEDICAL  
CENTER**

**Risk Management/  
Patient Safety Plan**

**Nevada Acute Care Division**

Revised 1/2020

## I. Overview

**SUMMERLIN Hospital** endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. **SUMMERLIN Hospital** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **SUMMERLIN Hospital** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **SUMMERLIN Hospital** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan ("Plan") provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **SUMMERLIN Hospital**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the "Just Culture" concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **SUMMERLIN Hospital** policies.

**SUMMERLIN Hospital** employees, contractors, vendors, and members of each facility's medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

### GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.

- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.
- Evaluation and documentation of the effectiveness of actions implemented.
- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

## II. Mission and Vision

**SUMMERLIN Hospital's** mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

**SUMMERLIN Hospital** recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

## III. ROLES AND RESPONSIBILITIES

## A. Risk Management/Patient Safety Officer

**SUMMERLIN Hospital** has a designated Risk Director/Manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) include:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

## B. Infection Control Officer

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee.
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the Patient Safety Plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World



Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a Certified Infection Preventionist.

## C. Patient Safety

**SUMMERLIN Hospital** has an established Patient Safety Council (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **SUMMERLIN Hospital** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to RiskConnect (STARS) and Midas) to maintain and manage PSWP.

### I. Facility Patient Safety Committee

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully. Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

#### Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

#### Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

#### **Duties and Responsibilities:**

**SUMMERLIN Hospital's** PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the Patient Safety Checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.

- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt Patient Safety Checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, The Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

## **II. Patient Safety Advisories**

When an untoward event occurs at the facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, Safety Watch newsletters are distributed. These alerts detail the circumstances that lead to a negative outcome and the facility is charged with assessment and improvement of their own processes to prevent similar occurrences. In addition, Clinical Risk Alerts and Medication Safety Alerts are also formulated to apprise the facilities of a specific safety issue that needs to be assessed to prevent reoccurrence.

**SUMMERLIN Hospital** is required to address the Safety Watch newsletters, Clinical Risk Alerts and Medication Safety Alerts via their Patient Safety Committee and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

## **C. TERM Program**

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

**Element I. Administration of the Risk Management Program:** The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

**Element II. Risk Identification:** Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

**Element III. Risk Education:** Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

**Element IV. Patient Safety Initiative:** Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC). The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

**Element V. Patient Safety Priority: Root Cause Analysis (RCA):** The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

**Element VI. Environment of Care; Safety and Security Programs:** The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

**Element VII. Claims and Litigation Management:** The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

**Element VIII. Patient Safety Organization (PSO):** Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

#### **D. MIDAS**

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

#### **E. Risk Connect (STARS)**

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by **SUMMERLIN Hospital's** RM to the Governing Board of all claims activities.

#### **F. Event Notification Site**

The Event Notification Site or ENS, is a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and management. The ENS also provides an environment in which

stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

### **G. Root Cause Analysis (RCA)**

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that The Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

#### **RCA Responsibilities**

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



## H. Patient Safety Checklists

By [NRS 439.865](#), the Patient Safety Plan must include the Patient Safety Checklists and Patient Safety Policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Patient Safety Checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

(For your reference— a checklist example is shown in **Appendix A.**)

## **I. Patient Safety Policies**

The Patient Safety Policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

## **J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)**

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out



patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

## K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired Risk Directors/Managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each Risk Director/Manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories
- Clinical Risk Alerts
- Medication Safety Alerts

## IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2020

- Surgical and Procedural Safety:
  - **Wrong Site Surgery (WSS).**
    - **Goal:** A 50% reduction in WSS events for 2020. Ultimately the goal is zero (0).
      - Monitor through Midas event reporting. Report monthly.
  - **Retained Procedural items (RPIs)**

- **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2020. Ultimately the goal for RPIs is 0.
      - Monitor through Midas event reporting. Report monthly.
  - **OBHRU:**
    - **Reduction/Elimination of serious harm by reducing the response time to adverse obstetrical bleeding initiative.**
      - **Goal:** As evidenced by:
        - Education Module X: All new hire staff and providers to complete Hemorrhage module within 1st 3 months of employment. All current staff and providers who care for perinatal patients to complete Hemorrhage module every 2 years (even years).
        - Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results of Power Insights Hemorrhage report/dashboard.
        - All patients will receive POST BIRTH warning signs education for inpatient stay and discharge as evidenced by Power Insights report on education completion.
        - POST BIRTH collaborative benchmarking and assessment data from AWHONN/Premier collaborative.
      - Monitor through Powers Insights QBL compliance report/Midas/ENS/Claims data, GNOSIS results, and facility education reports. Report monthly.
  - **CLABSI/CAUTI Initiative**
    - **Goal:** CLABSI and CAUTI will both be reduced to less than the National CMS mean Standardized Infection Ratio (SIR: CLABSI 0.783; CAUTI 0.857) in 2020.
    - Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly.
  - **Safe Medication Use**
    - Opioid Analgesic Event Reduction Initiative
      - **Goal:** Decrease the number of preventable OIRD events by 10%.
        - Monitor through MIDAS reports, Cerner, ICD-10 Codes, and other intervention data. Report monthly.
  - **Reduce Falls and Falls with Injury**
    - **Goal:** 10 % overall reduction in the number of falls in the facility by end of 2020.

- Review of the progressive mobility (PM) documentation in the facility.
  - Correlation of PM documentation and fall incidents.
  - Review of the documentation of PM in the ICU with LOS and length of intubation.
  - Review of documentation of mobility and progression of mobility.
  - Monitor through MIDAS event reporting. Report quarterly.
- **Culture of Safety**
    - **Goal:** 100% of 2020 Patient Safety Plan Priorities will be implemented within the facility.
    - Monitor through MIDAS event reporting with monthly reporting to PSC.

## **FACILITY GOALS**

- **Pediatric Sepsis Initiative**
  - **Goal:** 100% rapid recognition and resuscitation of sepsis in our pediatric population.
    - Review the 2020 guidelines Initial Resuscitation Algorithm for Children and compare to our current algorithm.
    - Update the Pediatric systemic inflammatory response syndrome vital signs and laboratory values by age.
    - Monitor through the use of a sepsis tool tracking form and report monthly.

## **V. Monitoring and Accountability**

### **A. Evaluation of TERM Program**

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

### **B. Patient Safety Committee**

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed and detailed feedback is provided to coach the committee on their form and function.

### **C. Dashboards**

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful

event rate, medication event rate including harmful medication events, timeliness of event review and closure.

## **VI. Evaluation/Review:**

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- The framework advances a “Just Culture” approach to patient safety
- Accountability is promoted when acts of “human error”, “at risk”, or “reckless behavior” are identified and corrected resulting in a reduction of potential/actual adverse outcomes.
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

## **VII. Confidentiality**

All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities. The PSC annually reviews the effectiveness of the Safety Plan to ensure goals and objectives are appropriately focused on improving patient safety.

## **VIII. Approval of Patient Safety Plan**

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the Governing Board of the facility for approval. After a facility’s patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The Patient Safety Plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.


According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current Patient Safety Plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

### ***Appendix A: Checklist Example: Injuries from Falls and Immobility***

| Process Change                                                                                                                                    | In Place | Not Done | Will Adopt | Notes (Responsible & By When?) |
|---------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|------------|--------------------------------|
| Conduct fall and injury risk assessment upon admission                                                                                            |          |          |            |                                |
| Reassess risk daily and with changes in patient condition                                                                                         |          |          |            |                                |
| Implement patient-specific intervention to prevent falls and injury                                                                               |          |          |            |                                |
| Communicate risk across the team; use handoff forms, visual cues, huddles                                                                         |          |          |            |                                |
| Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs) |          |          |            |                                |
| Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds               |          |          |            |                                |
| Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives                                                                        |          |          |            |                                |
| Incorporate multidisciplinary input for falls                                                                                                     |          |          |            |                                |
| Prevention from PT, OT, MD, RN and Phar.D.                                                                                                        |          |          |            |                                |

|                                                                                                                                             |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| <b>Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient</b> |  |  |  |  |
| <b>Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls</b>                         |  |  |  |  |

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

|                                                                                       |                                                                           |
|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
|      | <b>ORG.2404</b><br><b>Performance Improvement and Patient Safety Plan</b> |
| <b>Last Reviewed:</b> (04/2007); 04/2014; 01/2015; 02/2016; 02/2017; 01/2018; 01/2019 | <b>Replaces Policy Dated:</b> 04/2007; 04/2014; 01/2015; 02/2016; 02/2017 |
| <b>HCA Effective Date:</b> N/A                                                        | <b>Approved by BOT:</b> 04/2014; 01/2015; 08/2016; 03/2017; 02/2019       |
| <b>Submitted by:</b> Risk Management                                                  | <b>Page 1 of 14</b>                                                       |

## PURPOSE

Sunrise Hospital and Medical Center and Sunrise Children's Hospital (SHMC|SCH) develops, implements, and maintains an effective, ongoing, facility-wide, data-driven quality and patient safety assessment, and performance improvement program.

## SCOPE

Housewide

## POLICY/STRUCTURE

- A. SHMC|SCH has a leadership structure to support operations and the provision of care.
- B. Structure is formed by three (3) leadership groups:
  - 1. Board of Trustees (BOT), the organized medical staff which is represented by the Medical Executive Committee (MEC), and Senior Leadership.

## BOT

- A. BOT serves as the governing body legally responsible for the conduct of SHMC|SCH as an institution.
- B. BOT has ultimate responsibility for safety and quality which is derived from their legal responsibility and operational authority for SHMC|SCH performance.
- C. In this context, the BOT provides for internal structures and resources, including staff that supports safety and quality.
- D. Working with the MEC and Senior Leaders, the BOT establishes a mission, vision, and goals of the organization to support safety, quality of care, treatment, and services.
- E. Roles and responsibilities of the BOT in ensuring performance improvement (PI) and patient safety activities include:
  - 1. Reflects the complexity of SHMC|SCH organization and services; involves all SHMC|SCH departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.
  - 2. Identifies those responsible for planning, management, and operational activities.
  - 3. Identifies those responsible for the provision of care, treatment, and services.
  - 4. Defines in writing its responsibilities.
  - 5. Approves SHMC|SCH written scope of services.
  - 6. Selects and approves the Chief Executive Officer (CEO) responsible for managing SHMC|SCH.
  - 7. Works with the Senior Leaders and the MEC to annually evaluate SHMC|SCH performance in relation to its mission, vision, and goals.
  - 8. Ensures the ongoing program for quality improvement and patient safety is defined, implemented, and maintained.
  - 9. Establishes clear expectations for safety.

10. Provides the organized medical staff, represented by the MEC with the opportunity to participate in governance and the opportunity to be represented at BOT meetings.
11. Assumes full legal authority and responsibility for operations of SHMC|SCH and medical staff.
13. Establishes a process for making decisions when a leadership group fails to fulfill its responsibilities and/or accountabilities.
14. Provides for the resources needed to maintain safe, quality care, treatment, and services.
15. Provides a system for resolving conflict among individuals working within the organization.
16. Receives and reviews reports summarizing the data, analysis, findings, and recommendations related to facility-wide organizational PI Projects and Clinical Safety Improvement Program (CSIP).
17. Reviews the annual PI and CSIP Appraisal.
18. Approves the annual PI and Patient Safety Plan.

#### **Medical Staff and MEC**

- A. SHMC|SCH has an organized medical staff that is accountable to the BOT.
- B. Medical staff is represented by the MEC.
- C. Role and responsibilities of the MEC in ensuring PI and patient safety activities include:
  1. Organized and accountable to the BOT for the quality and safety of the medical care provided to the patients.
  2. Operates under Medical Staff Bylaws and Rules and Regulations approved by the BOT.
  3. Oversees the quality of care, treatment and services provided by those individuals with clinical privileges.
  4. Approves the PI and Patient Safety Plan (PSP) including the design of the PI and patient safety activities.
  5. Requires the Medical Staff departments to continuously assess and improve the quality of care and services provided, continue to evaluate the competence of individuals with or without clinical privileges (i.e., allied health providers) and provide information for the re-credentialing process.
  6. Requires the Medical Staff to maintain quality control programs, as appropriate.
  7. Systematically evaluates SHMC|SCH performance activities of departments, committees and functional teams by the review of minutes, reports, and inquiries directed to/from the departments or committees by the MEC.

#### **Senior Leaders**

- A. SHMC|SCH identifies the responsibilities of its Senior Leaders.
- B. Role and responsibilities of Senior Leaders in ensuring PI and patient safety activities include:
  1. CEO manages SHMC|SCH and leads the Senior Leadership group.
  2. Senior Leaders work with the organized medical staff and the governing body to define their shared and unique responsibilities and accountabilities.
  3. CEO, MEC, the Chief Nurse Officer (CNO), and the Vice-President (VP) of Quality Management (QM) work together to make certain that the facility-wide PI and CSIP along with training programs address identified problems.
  4. Discuss issues that affect SHMC|SCH and the population(s) it serves, including the following:
    - a. PI and Clinical Safety Improvement activities.



- b. Reported safety and quality issues.
  - c. Proposed solutions and their impact on SHMC|SCH resources.
  - d. Reports on key quality measures and safety indicators.
  - e. Safety and quality issues specific to the population served.
  - f. Input from the population(s) served.
- 5. Ensures the scope of the safety program includes the full range of safety issues, from potential to no-harm errors (e.g., near misses).
- 6. Provides and encourages the use of systems for blame-free internal reporting of a system or process failure.
- 7. Defines sentinel events and ensures the performance of credible serious event analysis in response to sentinel events.  
See: [SUNR.PSO.003 Patient Safety Serious Event Analysis Policy](#)
- 8. Selects one (1) high-risk process and conducts a proactive risk assessment at least every 18 months.
- C. Creates and maintains a culture of safety and quality throughout the organization.
- D. Organization regularly evaluates the internal culture of safety and quality using the Agency for Healthcare Research & Quality (AHRQ) Hospital Survey on Patient Safety Culture.
- E. Survey allows Leaders to:
  - 1. Prioritize and implement changes identified by the survey.
  - 2. Provide opportunities for all individuals who work in SHMC|SCH to participate in safety and quality initiatives.
  - 3. Develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
  - 4. Create and implement a process for managing behaviors that undermine a culture of safety.
  - 5. Provide education that focuses on safety and quality for all individuals.

#### **Patient Safety Officer (Nevada Revised Statutes [NRS] 439.870)**

- A. Organization has designated the Risk Manager as the Patient Safety Officer for the organization.
- B. Patient Safety Officer:
  - 1. Serves on the Quality Care and Patient Safety Committees (PSC).
  - 2. Promotes a culture of safety and the elimination of avoidable harm.
  - 3. Supervises the reporting of all sentinel events.  
See: [SUNR.PSO.003 Patient Safety Serious Event Analysis Policy](#)
  - 4. Reports all sentinel events and the actions taken to ensure the event does not reoccur.
  - 5. Takes action as deemed to be necessary to ensure the safety of patients as a result of an investigation of the event.

#### **Department Directors**

- A. Department Directors of each ancillary/nursing service area is responsible for all PI and Patient Safety activities as they relate to their specific areas.
- B. Directors are responsible for the continuous assessment and improvement of their department's performance, promotion of patient safety, and the maintenance of appropriate quality control programs.
- C. Directors are responsible for evaluating the effectiveness of care delivered in their departments and the clinical performance of their staff.
- D. Although it is recognized that process issues or deficiencies account for most variances in performance, when PI activities lead to a determination that an individual is unable or

unwilling to improve, modification of the individual's job assignment will occur or other appropriate action will be taken.

- E. Significant findings of PI or Patient Safety activities will be reported through the appropriate channels.

**PSC and Quality Care Committee (QCC)**

- A. PSC and the QCC are responsible to the BOT, MEC, and Senior Leaders for the overall operation of the PI and PSP.
- B. These interdisciplinary committees include but are not limited to, representatives from the BOT, Senior Leaders, Medical Staff, QM, Pharmacy, Nursing Leadership, Infection Control, Ancillary Services Directors, Patient Safety Officer, and Facility Safety Officer.
- C. On an annual basis the PSC and QCC performs an annual PI appraisal of the PI activities.
- D. At this meeting, current PI priorities, patient safety priorities, and associated activities are reviewed and evaluated.
- E. General functions of the PSC and QCC include:
  - 1. Collects data to monitor its performance.
  - 2. The BOT, MEC, and Senior Leaders set priorities for and determine the frequency of data collection.
  - 3. Measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, SHMC|SCH services, and operations.
- F. Collects data and reports to the MEC, and BOT.
- G. Types of data collected includes but is not limited to:
  - 1. Operative or other procedures that place patients at risk of disability or death.
  - 2. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.
  - 3. Adverse events related to using moderate or deep sedation or anesthesia.
  - 4. Use of blood and blood components.
  - 5. All reported and confirmed transfusion reactions.
  - 6. Results of resuscitation.
  - 7. Behavior management and treatment.
  - 8. Significant medication errors.
  - 9. Significant adverse drug reactions.
- H. SHMC|SCH considers collecting data on the following:
  - 1. Staff opinions and needs
  - 2. Staff perceptions of risk to individuals
  - 3. Staff suggestions for improving patient safety
  - 4. Staff willingness to report adverse events
- I. Patient perception of the safety and quality of care, treatment, and services.
- J. Evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.
- K. Effectiveness of its response to change or deterioration in a patient's condition.
  - 1. Note: Measures may include length of stay, response time for responding to changes in vital signs, cardiopulmonary arrest, respiratory arrest, and mortality rates before and after implementation of an early intervention plan.
- L. PSC shall have oversight of the SHMC|SCH Patient Safety Program, which includes but is not limited to:
  - 1. Review the annual PSP and Strategies.
  - 2. Collect data to monitor PSP performance.
    - a. Measure, analyze, and track safety indicators, including adverse patient

- events, and other aspects of performance that assess processes of care, SHMC|SCH services, and operations.
3. Types of data collected includes but is not limited to:
    - a. Patient safety related to the use of at least two (2) patient identifiers when giving medication, blood products, or before a procedure.
    - b. Infection Prevention as it relates to the use of proven guidelines such as hand cleaning to prevent infections of Catheter Associated Urinary Tract Infections (CAUTI), Central Line Associated Bloodstream Infections (CLABSI), Surgical Site Infections (SSI), and other SHMC|SCH acquired infections.
    - c. Safe surgical practices by prevention of mistakes made in surgery such as wrong patient, wrong site, and wrong procedure with use of standardized *Time Out* practices before any treatments or procedures.
    - d. Use of medication safety as it relates to the prevention of significant medication errors.
    - e. Evaluate the effectiveness of all fall reduction activities including assessment, interventions, and education.
    - f. Evaluate the effectiveness of the reduction of all SHMC|SCH acquired conditions (HAC) to improve health outcomes and reduce length of stay.
  4. Receive reports from the patient safety officer pursuant to NRS. 439.870
  5. Review and evaluate the quality of measures carried out by the medical facility to reduce the number of severity of sentinel events and infections that occur at the medical facility.
  6. Ensures all Patient Safety policies/checklists follow protocols to improve the health outcomes of patients at the medical facility and will include, without limitation:
    - a. Checklists related to specific types of treatment must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
    - b. Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
  7. Checklists to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
    - a. Proper instructions concerning prescription medications;
    - b. Instructions concerning aftercare; and
    - c. Any other instructions concerning his or her care upon discharge.
  - M. Ensure that a policy for appropriately identifying a patient before providing treatment the policy will require the patient to be identified with at least two (2) personal identifiers before each interaction with a provider of healthcare.
    1. The personal identifiers may include without limitation, the name, and date of birth of the patient.
  - N. Ensure that a policy regarding the nationally recognized standard precautionary protocols to be observed by providers of health care at the facility including, without limitation, protocols relating to hand hygiene.
  - O. Monitor and document the effectiveness of the patient identification (ID) policy.
  - P. At least annually, review and revise the patient safety checklists and patient safety

- policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
- Q. Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
  - R. Ensure that on or before July 1 of each year, the Patient Safety officer will submit a report to the Director of Legislation Counsel Bureau for transmittal to the Legislative Committee on Health Care.
    - 1. The report must include information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph (II).
  - S. Evaluate the recommendations provided to the executive or governing body of the medical facility regarding:
    - 1. The number of sentinel events that occurred at the medical facility during the preceding calendar quarter;
    - 2. The number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
    - 3. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
  - T. Evaluate the role of the Patient Safety Officer in the adoption of patient safety checklists and patient safety policies as required by NRS 439.877, including the review of the checklist and policies annually and revision of the checklists and policies as the patient safety committee determines necessary.
  - U. QCC compiles and analyzes data
  - V. Program includes, but is not limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and patient safety, including:
    - 1. Sets expectations for using data and information to improve the safety and quality of care, treatment, and services.
    - 2. Responsible for the implementation of successful corrective action plans in affected problem areas.
    - 3. Measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, SHMC|SCH service and operations.
    - 4. Develops, implements, and maintains an effective, ongoing, facility-wide, data-driven quality assessment and performance improvement program.
    - 5. Compiles data in usable formats.
    - 6. Uses statistical tools and techniques to analyze and display data.
    - 7. Analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.
    - 8. Compares data with external sources, when available.
    - 9. Analyzes its Organ Procurement conversion rate data as provided by the Organ Procurement Organization (OPO).
    - 10. Uses the results of data analysis to identify improvement opportunities.
  - W. In regard to staffing:
    - 1. When SHMC|SCH identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of

- staffing, including nurse staffing, in its analysis of possible causes.
- 2. When analysis reveals a problem with the adequacy of staffing, the Senior Leaders responsible for the facility-wide patient safety program are informed, of the results of this analysis and actions are taken to resolve the identified problem(s).
- 3. At least once a year, the leaders responsible for the facility-wide patient safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.
- X. QCC considers participation in Quality Improvement Organization (QIO) cooperative projects.
- Y. Trauma Program manages an intensive Performance Improvement and Patient Safety (PIPS) program regarding its practice.
  - 1. Minutes of the program's reviews are submitted to the MEC and the BOT through the Department of Surgery.
  - 2. In addition, members of the SHMC|SCH Quality Assurance Program attend the Trauma Peer Review Committee meetings.
- Z. PSC and QCC ensures the organization improves performance on an ongoing basis, including:
  - 1. Prioritizes the identified improvement.
  - 2. Takes action on improvement priorities.
  - 3. Evaluates actions to confirm that they resulted in improvements.
  - 4. Takes action when it does not achieve or sustain planned improvements.
- AA. PSC and QCC drafts priorities for the organization's PI activities, which are recommended for adoption through the MEC and the BOT.
- BB. QCC considers factors such as:
  - 1. Focus on high-risk, high-volume, or problem-prone areas,
  - 2. Consider the incidence, prevalence, and severity of problems in those areas.
  - 3. Affect health outcomes, patient safety, and quality of care.

#### **Patient Safety Organization (PSO)**

- A. SHMC|SCH is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided.
- B. To further this objective, SHMC|SCH contracted with Hospital Corporation of America (HCA) PSO, LLC (HCA|PSO|LLC), a federally certified PSO, to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.
- C. Generally speaking, patient safety work product (PSWP) is not subject to subpoena or discovery in State or Federal court, in administrative proceedings, or pursuant to the Freedom of Information Act (FOIA), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act (PSQIA) and its associated regulations. *(See 42 Code of Federal Regulations [CFR] § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.)*
- D. SHMC|SCH will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses (RCA), patient safety communications, quality reviews, and other documents aimed at improving patient safety.
- E. Documents will be submitted in a standardized format to allow for comparison with like Providers.
- F. As part of this effort, SHMC|SCH will operate a Patient Safety Evaluation System (PSES) designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC.

- G. PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes.
- H. Designated SHMC|SCH personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

**Methodology**

- A. FOCUS-Plan-Do-Check-Act (PDCA) is the methodology used for PI projects.
- B. Using this methodology data is systematically aggregated and analyzed on an ongoing basis.
- C. Statistical tools used are displayed in diagram II below.

**FOCUS****Find an Improvement Opportunity:**

- A. Review results of measurement activities and input from staff, patients, medical staff, and other customers.
- B. How are we doing compared to ourselves/external benchmarks over time?
- C. What situation yields an opportunity for improvement?
- D. What processes should be addressed first?

**Organize a Team that Knows the Process:**

- A. Is there representation from those who work in the process
- B. Educate the team on the PI process.
- C. Establish the team purpose, process and measures of team progress.

**Clarify Current Knowledge of the Process:**

- A. Is the process well defined, including the customers, their needs and expectations?
- B. Do our perceptions of the process relate to the actual process?
- C. “Flow chart” the process to determine the actual flow or sequence of events that the process follows.
- D. What is the baseline data on the current process?
- E. Review recent scientific literature for up to date information regarding the process.

**Uncover Root Cause of the Process Variation:**

- A. “Fishbone” a cause and effect diagram to allow the team to identify, explore and graphically display, in increasing detail, all of the possible causes related to a problem.
- B. Are the causes the root cause or just symptoms of the problem?
- C. What are the causes that have the greatest impact in priority order?

**Start the Improvement Cycle:**

- A. What new knowledge have you acquired about the process?
- B. What changes need to be made to improve the process?

**PDCA****Plan Improvement**

- A. Who, what, when and how are we going to change the process
- B. Data collection-who, what, where, when and how are we going to track the process change?
- C. Identify those forces that assist or prevent change-force field analysis.

**Do Improvement:**

- A. Implement change

**Check Results:**

- A. Do results match the expectations?
- B. What was learned?
- C. What does the team want to continue to do?



- D. What would the team do differently?

#### Act

**(To sustain improvement and continue to improve or abandon change and start cycle again)**

- A. What part of the process needs to be standardized?
- B. What policies/procedures need to be revised?
- C. Who needs to be trained?
- D. Determine method for ongoing measurement.

#### Serious Event Analysis

- A. Is the primary PI methodology used for analysis of significant unanticipated outcomes and/or Sentinel Events.

See: [SUNR.PSO.003 Patient Safety Serious Event Analysis Policy](#)

#### EXTERNAL DATA SOURCES

- A. Data is also collected as indicated for participation in the following external databases or for participation with the following organizations:

##### Lavanta

- A. Centers for Medicare & Medicaid (CMS) contracted Quality Improvement Organization (QIO) has developed Healthcare QI Initiatives that examine patterns of practice.
- B. Areas for study are suggested by practitioners in the community, university, hospital settings, nationally recognized patient safety and quality improvement organizations and CMS.
- C. Studies enable hospitals and medical staff to compare their performance with what may be optimal levels of practice.

#### Comprehensive Health Outcomes Information System (CHOIS) Reports

- A. CHOIS is designed to identify opportunities for improvement, identify best practices, and manage resources appropriately, effectively, and efficiently.
- B. Clinical Outcome Summary Reports are distributed on a quarterly basis.
- C. Data captured in this report reflects numerous clinical indicators.
- D. These indicators were developed through medical staff focus groups.
- E. Data is risk and severity adjusted using CMS's Refined diagnosis-related group (DRG)s and economic cycle research institute (ECRI), a risk index used to adjust complication rates, Risk Adjusted Mortality Index (RAMI) and the Risk Adjustment Specialty Algorithm (RASPEC) as appropriate.
- F. Each hospital is provided with actual and risk adjusted mortality and complication rates.
- G. Rates are compared to the company overall and national statistics.
- H. Patient and Provider level details are provided to facilitate a detailed analysis of the cases reflected in the data.

#### The Joint Commission (TJC) Measurement System (ORYX)

- A. This is TJC initiative to integrate performance measures into the accreditation process.
- B. It involves a collection of service, process and outcome indicators related to specific patient populations.
- C. Data for this initiative is collected through the Comprehensive Outcomes Measurement Evaluation and Transmission (COMET) database.
- D. Information is collected at the facility level and transmitted directly to TJC from HCA, as the chosen vendor for this project.
- E. Data abstracted through the COMET system are also submitted to CMS for public reporting through the Hospital Compare website.
- F. Hospital Compare website was created through the efforts of the CMS, an agency of the United States Department of Health and Human Services (DHHS), along with the

- Hospital Quality Alliance (HQA).
- G. HQA is a public-private collaboration established to promote reporting on hospital quality of care.
- H. HQA consists of organizations that represent consumers, hospitals, Providers and nurses, employers, accrediting organizations, and Federal agencies.
- I. Information on this website can be used by any adult needing hospital care.

#### **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**

- A. HCAHPS is a national, standardized, publicly reported survey of patients' perspectives of hospital care.

#### **Vermont Oxford Neonatal Database**

- A. Oxford Neonatal Database is a comprehensive database of 600 plus neonatal intensive care (NICU) centers which compares morbidity, mortality, and length of stay data on the very low birth weight infants (501 to 1500 grams).
- B. As part of this network, the neonatal intensive care quality benchmarking project applies a team approach to health care benchmarking with the goal of improving the effectiveness and efficiency of neonatal intensive care.

#### **Cancer Registry**

- A. Cancer Registry submits cancer data on select neoplasms to the State of Nevada Administrative Code (NAC) 457.010 to 457.040.
- B. Data is generally requested annually.
- C. Cancer Registry department manages the cancer program and the American College of Surgeon's Commission on Cancer accreditation.
- D. Accreditation program maintains a robust set of metrics pertaining to 37 standards for the diagnosis, treatment and follow-up of cancers.
- E. As part of the accreditation, the Cancer Registry collects data adhering to the Commission of Cancer (COC)s strict criteria and submits data to the National Cancer Data Base (NCDB).
- F. Data is submitted to the NCDB at schedule intervals.
- G. NCDB data is used nationally to identify areas for quality improvement as well as direct other important activities.
- H. NCDB database is available at a facility level providing tools such as hospital comparison benchmarks, survival reports, Cancer Program Practice Profile Reports, Rapid Quality Reporting System, and the Cancer QI Program data reports.
- I. COC used NCDB data to direct participating organizations to perform special studies throughout the year.

#### **Trauma Registry**

- A. Trauma Registry at Sunrise is a State of Nevada database.
- B. Nevada Trauma Registry (NTR) data is collected from all licensed acute care hospitals and trauma centers in Nevada.
- C. NTR can provide information on the incidence, and prevalence, morbidity, and mortality of injuries in Nevada.
- D. Data can be broken down to a specific county, specific hospital, specific race, or specific age group, for example.
- E. Data are available for state, private or federal entities, grant applicants to measure the impact of trauma on Nevada and initiate health education programs that address traumatic injuries.

#### **Society of Thoracic Surgeons (STS)**

- A. Offers outcome programs in the areas of Adult Cardiac, General Thoracic, and Congenital surgery.



- B. By committing to collecting outcomes data to the STS National Database, surgeons are committing to improving the quality of care that their cardiothoracic surgery patients receive.
- C. SHMC|SCH participates in the STS database, using the national comparisons and benchmarking as an integral part of the PI program for Cardiovascular Services.

#### **American College of Cardiology (ACC)/National Cardiovascular Data Registry (NCDR)**

- A. NCDR is the recognized resource for measuring and quantifying outcomes and identifying gaps in the delivery of quality cardiovascular patient care in the United States.
- B. Its mission is to improve the quality of cardiovascular patient care by providing information, knowledge and tools, implementing quality initiatives, and supporting research that improves patient care and outcomes.

#### **Perinatal Services Quality Initiative**

- A. Perinatal Services Program is an HCA Corporate Initiative to improve perinatal services and reduce the risk associated with the delivery of maternal and infant care.

#### **Emergency Management Risk Initiative**

- A. Emergency Management Risk Initiative audit is one of the fundamental elements in the creation of the risk managed Emergency Department (ED).
- B. This is the most powerful audit tool available in emergency medicine.
- C. It is clinically oriented and provides an unprecedented look at the individual practitioner, the emergency practitioners as a group, and ED systems.
- D. Audit is accomplished through the Sullivan Group via an agreement with HCA hospitals.
- E. SHMC|SCH participates on a semi-annual basis.

#### **Get with the Guidelines GWTG™**

- A. Stroke Management Tool (Outcome Sciences) is a comprehensive quality management measurement tool that captures critical information regarding the care and treatment of patients with an acute stroke, with an emphasis of secondary prevention.
- B. Database is used to assess and measure internal compliance of treatment standards, and the ability to provide concurrent comparison to external entities and provides national benchmarks.

#### **ACTION Registry®-GWTG™**

- A. ACTION Registry is a risk-adjusted, outcomes-based quality improvement program that focuses exclusively on high-risk ST Elevation Myocardial Infarction (STEMI)/non-ST (NSTEMI) patients.
- B. It helps hospitals apply American College of Cardiology (ACC)/American Heart Association (AHA) clinical guideline recommendations in their facilities and provides invaluable tools to measure care and achieve quality improvement goals.

#### **Leapfrog**

- A. Leapfrog Hospital Survey is the public reporting initiative launched in 2001 by the Leapfrog Group.
- B. Leapfrog Group is an independent, not-for-profit organization aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded.
- C. Leapfrog strives to make giant "leaps" forward in safety, quality, and affordability of healthcare by promoting transparency.
- D. Leapfrog Group Survey assesses hospital performance based on 28 different metrics.
- E. Leapfrog algorithm computes a letter grade reflecting the hospital's performance based on these metrics.
- F. Currently nine (9) different Safe Practices are assessed.

- G. These safe practices, created by the National Quality Forum (NQF), have been found to reduce preventable medical mistakes.
- H. Leapfrog works to continually assess safe practices and new practices are added or removed accordingly.
- I. Leapfrog algorithm also analyzes 18 data points from the publically reported data as required by the CMS.

**National Healthcare Safety Network (NHSN) Database**

- A. NHSN is a secure, internet-based surveillance system that integrates former Center for Disease Control (CDC) surveillance systems, including the National Nosocomial Infections Surveillance System (NNIS), National Surveillance System for Healthcare Workers (NaSH), and the Dialysis Surveillance Network (DSN).
- B. NHSN enables healthcare facilities to collect and use data about HAC infections, adherence to clinical practices known to prevent HAC infections, the incidence or prevalence of multidrug-resistant organisms within their organizations, trends and coverage of healthcare personnel safety and vaccination, and adverse events related to the transfusion of blood and blood products.

**REFERENCES**

§482.21 Condition of Participation: Quality Assessment and Performance Improvement Program  
NAC 449.3152 Quality Improvement Program  
NRS 439.865 Patient Safety Plan  
NRS 439.870 Patient Safety Officer  
NRS 439.875 Patient Safety Committee  
Joint Commission Requirements for Performance - Performance Improvement Chapter

## PERFORMANCE IMPROVEMENT REPORTING STRUCTURE

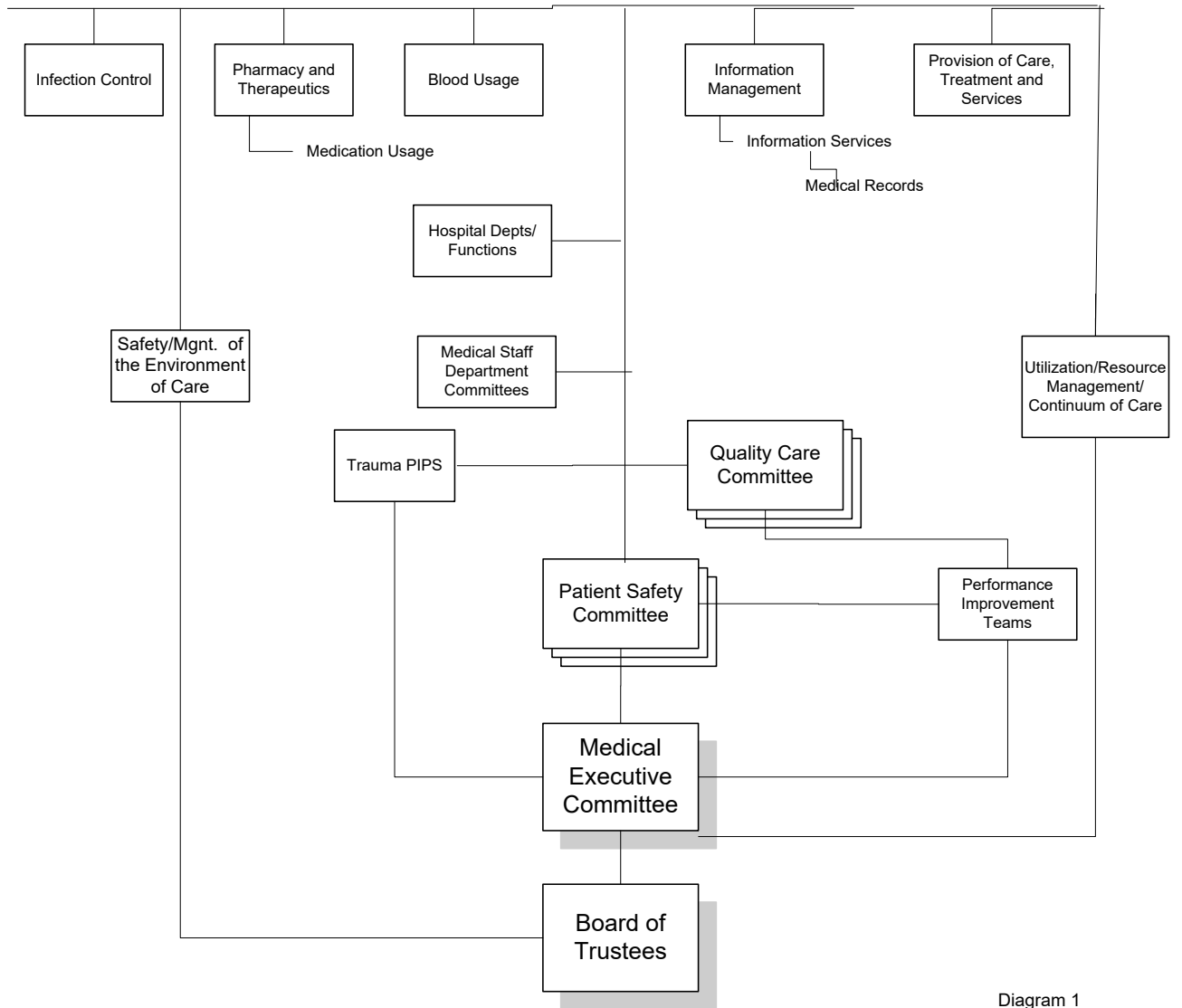
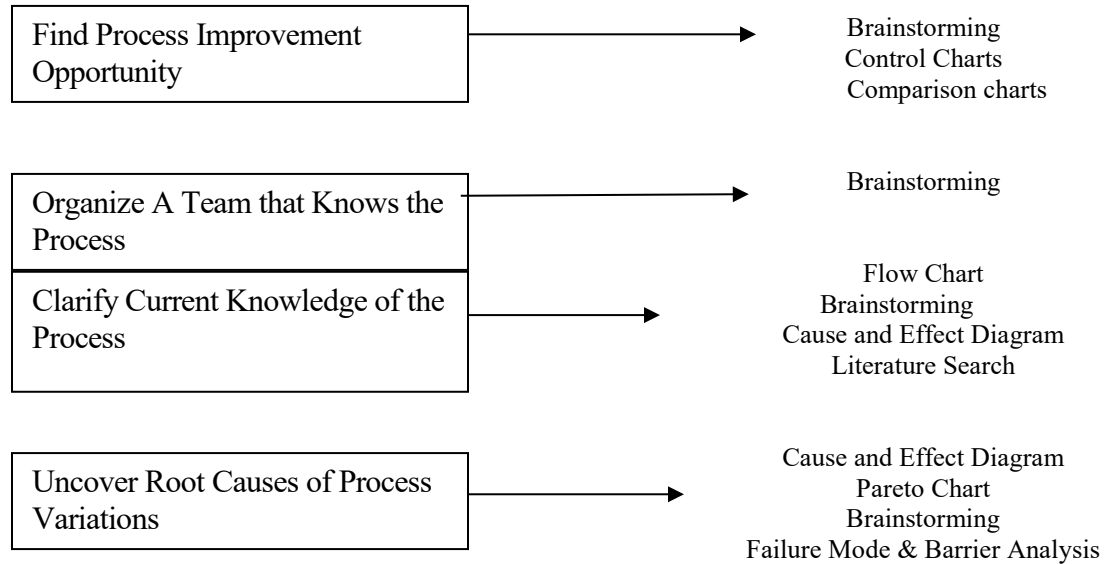
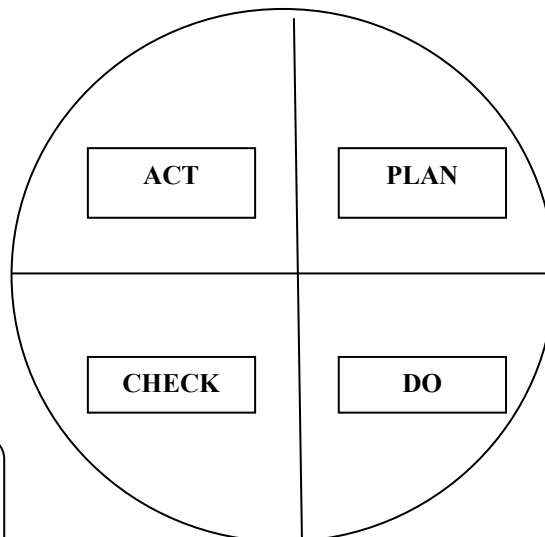


Diagram 1

**FOCUS - PDCA****1. Start**

PDCA Improvement

Brainstorming  
Cause & Effect DiagramBrainstorming  
Checklist  
Cause and Effect Diagram  
Force Field AnalysisPareto Charts  
Run Charts  
Control ChartsChecklist  
Implementation  
Guidelines

## SUNSET RIDGE SURGERY CENTER LLC

|          |                              |                 |           |
|----------|------------------------------|-----------------|-----------|
| MANUAL:  | Policy & Procedure           | Effective Date: | 7/21/2014 |
| SECTION: | Safety Management Plan       | Reviewed Date:  | 7/17/2019 |
| POLICY:  | 14.20 Patient Safety Program | Revised Date:   |           |

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**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



# 2019 Hospital 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.

## Improve staff communication

NPSG.02.03.01

Get important test results to the right staff person on time.

## 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.

## Use alarms safely

NPSG.06.01.01

Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

## 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.07.03.01

Use proven guidelines to prevent infections that are difficult to treat.

NPSG.07.04.01

Use proven guidelines to prevent infection of the blood from central lines.

NPSG.07.05.01

Use proven guidelines to prevent infection after surgery.

NPSG.07.06.01

Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

## Identify patient safety risks

NPSG.15.01.01

Find out which patients are at risk for suicide.

## Prevent mistakes in surgery

UP.01.01.01

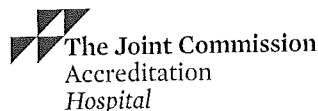
Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

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).

## **SURGERY CENTER OF RENO**

**Section: 5.3**

**Policy: Quality Management and Improvement**

**Subject: SENTINEL EVENT REPORTING**

**Effective Date: 2-06**

**Revised: 2-07, 2-08**

**Page 1 of 3**

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

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

### **DEFINITIONS:**

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

## **SURGERY CENTER OF RENO**

**Section: 5.3**

**Policy: QUALITY MANAGEMENT AND IMPROVEMENT**

**Subject: SENTINEL EVENT REPORTING**

**Effective Date: 2-06**

**Revised: 2-07, 2-08**

**Page 2 of 3**

**Reviewed: 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15  
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### **PROCEDURAL DOCUMENTATION:**

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

## SURGERY CENTER OF RENO

Section: 5.3

Policy: QUALITY MANAGEMENT AND IMPROVEMENT

Subject: SENTINEL EVENT REPORTING

Effective Date: 2-06

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### Who Should Know This Policy

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

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

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

## **SURGERY CENTER OF RENO**

### **Section 8, D Environment of Care Management Plan**

#### **Policy: Facilities and Environment**

#### **Subject: Environment of Care Emergency Management Plan, Codes**

**Effective Date: 2-06**

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

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### **ENVIRONMENT OF CARE MANAGEMENT PROGRAMS AND EMERGENCY PLAN**

#### **POLICY:**

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

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

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

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

## SURGERY CENTER OF RENO

### Section 8, D Environment of Care Management Plan

#### Policy: Facilities and Environment

#### Subject: Environment of Care Emergency Management Plan, Codes

Effective Date: 2-06

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

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#### PROCEDURE:

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

## SURGERY CENTER OF RENO

### Section 8, D Environment of Care Management Plan

#### Policy: Facilities and Environment

#### Subject: Environment of Care Emergency Management Plan, Codes

Effective Date: 2-06

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

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

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

E. Through HAVBED and Web EOC at <https://eoc.washoecounty.us/eoc7/default.aspx>, the disaster coordinator will communicate with the local Emergency Management Department officials to determine, based on the size and scope of services, if SCOR will participate in local Emergency Preparedness Drills and disasters. The Administrator and DON are registered with the Washoe County IHCC for emergency notifications via email, home and cell phones, on situations affecting the community. Notifying the local 911 services typically does this. Attached is the Washoe County Medical Unit leader contact list for direct notification to community leaders. Alternate methods of communication have been identified in the event there is a loss of telephone service. These include, but are not limited to, the use of digital pagers, cellular telephones, battery-operated radios, etc. Provided there is no danger to employees by leaving the building, Business Office personnel will be assigned, as appropriate, to travel by personal car to locate public telephones or to notify appropriate authorities such as Police, Fire and Emergency Medical Services of needed assistance.

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

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

## **SURGERY CENTER OF RENO**

### **Section 8, D Environment of Care Management Plan**

#### **Policy: Facilities and Environment**

#### **Subject: Environment of Care Emergency Management Plan, Codes**

**Effective Date: 2-06**

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

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**Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,  
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the decision will be made to evacuate the entire facility. The Administrator and/or safety officer will make this decision. The emergency management plan addresses specific procedures to be followed in the event an evacuation of the facility is deemed appropriate, as well as alternate roles and responsibilities of key personnel. See individual policies on each disaster scenario under facilities and environment. Communication of Center closure or surgery cancellations will be performed by the management team. In the event of an emergency during operational hours, the receptionist will keep a detailed log of each patient and their families disposition, by referencing the surgical schedule for that day and report to the Administrator or Alternate of any persons not accounted. Referencing the staffing schedule, the nurse manager will validate the location and safety of all staff members and track their location in the event of an evacuation.

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

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

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



## SURGERY CENTER OF RENO

### Section 8, D Environment of Care Management Plan

#### Policy: Facilities and Environment

#### Subject: Environment of Care Emergency Management Plan, Codes

Effective Date: 2-06

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

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needs of staff and patients within the ASC. The Center is supplied with emergency food and water in the event of a shelter in place scenario.

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

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

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

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

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

#### Who Should Know This Policy

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

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

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

## **SURGERY CENTER OF RENO**

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

#### **Policy: Emergency Preparedness Plan**

#### **Subject: Cardiopulmonary Arrest, Code Blue**

**Effective Date: 2-06**

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

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**Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,  
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### **IV. CARDIOPULMONARY ARREST – CODE BLUE**

#### **POLICY:**

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

#### **PROCEDURE:**

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

## SURGERY CENTER OF RENO

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

#### Policy: Emergency Preparedness Plan

#### Subject: Cardiopulmonary Arrest, Code Blue

Effective Date: 2-06

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

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Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,  
3-16, 4-16, 3-17, 3-18, 3-19

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- E. In most instances it is a PACU nurse who is responsible to bring the crash cart in the event of Code Blue being called. The crash cart is to be taken to the site where the code is called. Additional nursing staff will remain with other patient's.
- F. Signs shall be posted at all patients entrances, indicating the *Surgery Center of Reno* is not equipped to handle, and therefore does not provide emergency assistance. If persons from the community present themselves to SCOR requiring emergency services, staff will administer appropriate temporary emergency treatment and BLS to stabilize the patient and will IMMEDIATELY call "911" for the appropriate emergency response team. The Nurse/staff member will complete any required forms and a Facility Occurrence Report. All documentation will be forwarded to the Administrator. Saint Mary's security office can be notified at 770-3135 or the main hospital number at 770-3000 and call a code 250, someone from the ER will respond with a wheelchair and supplies to provide basic care.
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#### Who Should Know This Policy

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|                                        |                                                    |                                                       |
|----------------------------------------|----------------------------------------------------|-------------------------------------------------------|
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☒ Director of Nursing

## **SURGERY CENTER OF RENO**

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

#### **Policy: Emergency Preparedness Plan**

#### **Subject: Cardiopulmonary Arrest, Code Blue**

**Effective Date: 2-06**

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

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- A. The anesthesiologist will be primarily responsible for conducting Code Blue. If an anesthesiologist is not available, the physician performing the surgery or procedure will be responsible, as well as ACLS nurses responding to and readily available within the facility. In the event that there is not a physician present, ACLS guidelines will be followed and 911 dispatched.
- B. The receptionist/nursing personnel will:
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  2. Copy patient chart in preparation for transfer to hospital, by other available personnel.
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## SURGERY CENTER OF RENO

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

#### Policy: Emergency Preparedness Plan

#### Subject: Cardiopulmonary Arrest, Code Blue

Effective Date: 2-06

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Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,  
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#### Who Should Know This Policy

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| <input type="checkbox"/> PACU Staff    | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator     |

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☒ Director of Nursing

## **SURGERY CENTER OF RENO**

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

#### **Policy: Emergency Preparedness Plan**

#### **Subject: Bomb Threat, Code Black**

**Effective Date: 2-06**

**Revised: 6-08, 8-11**

**Page 1 of 2**

**Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,  
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### **IV.B.2 BOMB THREAT –Code Black**

#### **POLICY:**

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

#### **PROCEDURE:**

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

**A. Employee receiving the call will:**

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

**B. Administrator or Acting Person in Charge will:**

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

**C. All Personnel:**

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

**D. Following the evacuation:**

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

## SURGERY CENTER OF RENO

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

#### Policy: Emergency Preparedness Plan

#### Subject: Bomb Threat, Code Black

Effective Date: 2-06

Revised: 6-08, 8-11

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c) Cooperate with all agencies present.

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

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#### Who Should Know This Policy

|                                        |                                                    |                                                       |
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| <input type="checkbox"/> PACU Staff    | <input type="checkbox"/> All Business Office Staff | <input checked="" type="checkbox"/> Administrator     |

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☒ Director of Nursing

## SURGERY CENTER OF RENO

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

#### Policy: Emergency Preparedness Plan

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

Effective Date: 2-06

Revised: 6-08, 8-11

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Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15,  
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### IV. B.3. EARTHQUAKE, FLOOD, HEAT WAVE, THUNDERSTORMS – Code Grey

#### POLICY:

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

#### PROCEDURE:

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

<https://www4.emsystem.com/EMSystem>. As part of the IHCC, the Administrator or Director of Nursing will notify the Washoe County Emergency Management team for instructions during a disaster (see attached Washoe County Health District contact list) or thru WebEOC at <https://eoc.washoecounty.us/eoc7/default.aspx>.

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

#### A. During the earthquake:

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

##### a) If you are indoors:

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

##### b) If you are outdoors:

- (1) Stay away from buildings, power lines, towers, poles, trees, etc.
- (2) Lie flat on the ground until shaking stops.



## **SURGERY CENTER OF RENO**

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

#### **Policy: Emergency Preparedness Plan**

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

**Effective Date: 2-06**

**Revised: 6-08, 8-11**

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

## **SURGERY CENTER OF RENO**

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

#### **Policy: Emergency Preparedness Plan**

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

**Effective Date: 2-06**

**Revised: 6-08, 8-11**

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#### **D. Inspect facilities and prevent further damage:**

1. Check utility connections for damage or leaks. Repair essential utilities if possible. Secure and tag all non-essential utilities.
2. Take steps to restore essential services, if necessary.
3. Establish communication channels with authorities and advise of:
  - a) Numbers and types of casualties, internally.
  - b) Extent of damage to SCOR's facilities.
  - c) Determine possible options for the most efficient use of available facilities and services in the open.
4. Inspect SCOR to determine if evacuation of patients and staff is necessary.
5. Minimize required traveling and transport needs.

#### **E. Reduce post-quake environmental hazards:**

1. Secure areas in or around building which pose a danger to pedestrians because of falling objects or other damage.

### **II. Floods:**

#### **A. When a Flood Watch is issued and it affects the SCOR:**

1. Be alert to signs of flash flooding
2. Listen to local radio and TV stations for information and advice.

#### **B. When a Flood Warning is issued:**

1. Be prepared to evacuate staff and patients if evacuation for the area is issued by the State Emergency System. Depending on the progress of the surgery or procedure, the physician will abort or complete the on-going surgery or procedure. All patients in PACU will be recovered until the discharge criteria has been met and the patient can safely be discharged. All remaining surgeries or procedures will be cancelled.

### **III. Heat Wave:**

- A. If the State Emergency System issues a heat wave advisory, the occupants of the SCOR will be warned of the Advisory and are instructed on safety measures when leaving the SCOR. Water and non caffeinated fluids are offered to occupants as they leave.

- B. Window coverings in the SCOR will be drawn to help decrease the penetration of the heat into the facility.

### **IV. Thunderstorms:**

- A. During a thunderstorm, the occupants are encouraged to remain in the SCOR until it

## SURGERY CENTER OF RENO

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

#### Policy: Emergency Preparedness Plan

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is safe to leave SCOR. Move occupants away from windows.

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

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#### Who Should Know This Policy

|                                        |                                                    |                                                       |
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## SURGERY CENTER OF RENO

### Section 8, D-IV. B.4

#### Policy: Facilities and Environment

#### Subject: Emergency Preparedness –Malignant Hyperthermia

Effective Date: 2-06

Revised: 2-08

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Reviewed: 2-07, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 3-19

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

##### POLICY:

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

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

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

##### PROCEDURES:

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

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

##### B. Patient with MH Crisis

1. Malignant hyperthermia is life threatening and time is of the essence. Upon first indication, with the orders of the physician in charge of this crisis, call MH HOTLINE 1-800-644-9737 and 911.
2. The SCOR keeps 36 vials of Dantrolene on hand for the purposes of treating malignant hyperthermia. The patient will be transferred once the malignant hyperthermia treatment has been initiated and the patient has been stabilized.

##### C. Responsibility

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

## SURGERY CENTER OF RENO

### Section 8, D-IV. B.4

#### Policy: Facilities and Environment

#### Subject: Emergency Preparedness –Malignant Hyperthermia

Effective Date: 2-06

Revised: 2-08

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- d. Document events on MH documentation record until a second licensed nurse arrives, then reassign documentation to him/her.
  - e. Circulator or available nurse to call MH Hotline for additional management advice as instructed by the anesthesiologist.
  5. PACU Nurse:
    - a. Retrieve Crash Cart and MH cart ( if not already present)
    - b. Designate/delegate duties according to color coded assignment cards:  
White cards= non clinical staff and Pink cards= licensed clinical staff.
    - c. Assist in mixing Dantrolene.
    - d. Start cooling measures (ice to groin and axilla, cold IVs, cold saline irrigation-provide cold saline to anesthesiologist for nasal gastric irrigation). **DO NOT OVERCOOL** (stop active cooling measures when patient reaches a core temp of 38°C or 100.4°F.)
  6. OR personnel or designee
    - a. Call Administrator and Director/Clinical Managers for additional help in OR.
    - b. OR cases in progress will proceed if an MH crisis is in progress, but no further cases will be started until after the MH crisis has stabilized.
    - c. Assist in making ice packs; bring bags of ice from lounge freezer; check with circulator and, if necessary, obtain more bags of ice as instructed.
    - d. Call 911 as instructed by the anesthesiologist when transfer arrangements have been completed.
  7. The licensed nurse will follow transfer policy and copy chart appropriately.
  8. An Occurrence Report is to be filled out in the event of an MH episode.
  9. A meeting will be scheduled by Nursing Leadership including those present during MH episode to critique and evaluate the response.

#### D. Equipment

1. Malignant hyperthermia cart; see list for inventory, retrieve cold Saline solutions from PACU MH refrigerator and ice.

#### E. Signs and Symptoms

1. Unanticipated doubling or tripling of end-tidal carbon dioxide.
2. Skeletal muscle rigidity (even in presence of neuromuscular blockage).  
\*NOTE: Masseter muscle spasm after use of Succinylcholine may be associated with malignant hyperthermia.
3. Tachypnea, tachycardia, unstable blood pressure, cyanosis
4. Hypoxemia
5. Myoglobinuria (cola-colored urine)
6. Increased temperature, fever (may be a late sign)

#### F. Treatment

1. As outlined in Emergency Treatment for Malignant Hyperthermia (See below)
2. Documentation: On-going documentation will be completed by an RN

#### General Outline of Emergency Treatment for Malignant Hyperthermia

#### PROCEDURE: Acute Phase

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

## SURGERY CENTER OF RENO

### Section 8, D-IV. B.4

#### Policy: Facilities and Environment

#### Subject: Emergency Preparedness –Malignant Hyperthermia

Effective Date: 2-06

Revised: 2-08

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

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

#### Who Should Know This Policy

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

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

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

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**POLICY:** The goal of SCOR is to provide safe efficient emergency care to our patients, staff members, and visitors in the event of an external disaster. As a surgery center in the event of a disaster, we would coordinate with HAVBED or the Washoe County Health District to provide information of our capabilities and how we could play a part in disaster relief. We would volunteer our facility and/or supplies as recommended by the Administrator and / or Board of Director Members. Our facility may be able to provide the following services:

- Low volume emergency supplies, linen, equipment and volunteer personnel
- Triage station and / or first aid station for minor injuries
- Coordinate disaster relief efforts with Saint Mary's Hospital in the event they needed to off-load less acute patients to take care of acutely injured patients

<https://eoc.washoecounty.us/eoc7/default.aspx>

**DEFINITION:** In the event of an emergency that may be caused by an act of terrorism, integration of services is necessary to meet the needs of the community without jeopardizing the health and safety of our patients and staff. As applicable SCOR will abide by state and national directives for external disaster

#### **PROCEDURE:**

1. HAVBED, Civil Defense, Police, Fire Department, and/or EMS will:

- a. Notify SCOR of disaster.
- b. Web access to HAVBED is [www.emresource.emsystem.com](http://www.emresource.emsystem.com)
- c. Web access to Washoe County Health District is WebEOC at <https://eoc.washoecounty.us/eoc7/default.aspx>

2. Employee receiving call will:

- a. Write the following information:
  - (1) Name of caller
  - (2) Organization (fire department, police, etc.)
  - (3) Time of call
  - (4) Type of disaster
  - (5) Location of disaster
  - (6) Type of injuries
  - (7) As applicable, estimated time of arrival at SCOR
  - (8) As applicable Number of injuries
  - (9) Notify Administrator/Director/Clinical Manager and repeat information obtained from the caller

3. Administrator:

- a. Call a meeting with Medical Director (if possible) and Nursing Staff to determine how to best accommodate and provide care to patients, staff members, and visitors in SCOR.
- b. Notify the Receptionist at the front desk if public address announcement deemed necessary.

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- c. Establish a command post location at the Administrator's discretion, and relay this information to the Receptionist.
  - d. Set in motion any appropriate disaster plans deemed necessary in coordination with HAVBED system and the Washoe County Health District.
  - e. Maintain communication with Defense authorities on current status.
  - 4. Any employee will:
    - a. If instructed to do so by the Administrator, announce "*Code Yellow, External-Home*" and command post telephone over intercom. The announcement is made three (3) times.
  - 5. All employees will:
    - a. Those employees involved with patient care will remain with the patient. All others will report to their immediate Supervisor for further instructions.
  - 6. Nursing Staff will:
    - a. Enforce open telephone line conditions in order to receive special assignments from SCOR Administration and authorized state and/or regulatory officials, such as the CDC.
  - 7. Patients and Visitors will:
    - a. Remain at SCOR until given an "all clear" by the Administrator to leave.
  - 8. Off-Duty Personnel will:
    - a. Stay at home during state of emergency unless instructed otherwise.
- 

### Section I: General Categorical Recommendations for Any Suspected Bioterrorism Event

#### A. Reporting Requirements and Contact Information- Chain of Command COMMUNICATION CHAIN OF COMMAND

- 1. To assure that consultation and notification of local, state and federal officials is properly coordinated during a suspected or confirmed bioterrorism event, a Bioterrorism Notification Matrix should be implemented. Should it be determined that SCOR's Emergency Management Plan must be activated, all routine emergency management policies and procedures would be followed in addition to the Bioterrorism Plan.
- 2. If there is an announced bioterrorism attack, which would affect the local area serviced by SCOR, the plans should be activated. The difficulties may arise during a covert attack when affected patients are unexpected.



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3. Confirmation of a bioterrorism event requires consultation between local, state and federal law enforcement and health officials. Since this will take some time, the activation of SCOR's wide Emergency Management Plan is not necessary or recommended unless there is a large influx of patients which the available staff cannot accommodate. Communication with the media regarding a perceived or real event should be handled at this time by public health officials or the FBI.
4. Internal notification when a bioterrorism attack is *suspected* is categorized by Primary and Secondary Notification. Until an event is confirmed, the plan is not activated and the usual staff notification is not necessary or prudent.
5. Primary Notification would include SCOR's Administrator, Safety Officer, Director/ Clinical Managers and Medical Director. The QI committee/Infection Control Nurse, in conjunction with the Administrator and Medical Director determines that there is probable concern, local law enforcement officials (which may include FBI field offices) and the Local Health Department are notified.
6. If the Bioterrorism event is confirmed, the Secondary Notification list is activated as well as SCOR's wide Emergency Management Plan.
7. The Local Health Department will notify the FBI and the State Health Department who in turn will notify the CDC. At this time, any communication with the media should go through SCOR's Administration or the Local Health Department. All policies regarding patient confidentiality shall be followed.

**INTERNAL CONTACTS** – See Bioterrorism Notification Matrix at end of Policy.

#### **EXTERNAL CONTACTS**

WASHOE COUNTY HEALTH DEPARTMENT: 775-328-2400

WASHOE COUNTY HEALTH DISTRICT; EPIDEMIOLOGY DIVISION: 775-326-6049 or  
775-328-2447

FBI FIELD OFFICE – 775-825-6600

BIOTERRORISM EMERGENCY NUMBER, CDC EMERGENCY RESPONSE OFFICE:  
770-488-7100

CDC HOSPITAL INFECTIONS PROGRAM: 404-639-6413

WASHOE COUNTY EMERGENCY MANAGEMENT: 775-337-5898

ENVIRONMENTAL PROTECTION AGENCY: 415-947-8000

See Bioterrorism Notification Matrix at end of Policy.

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#### **B. Potential Agents**

Four diseases with recognized bioterrorism potential (anthrax, botulism, plague, and smallpox) and the agents responsible for them are described in Section II of this document. The CDC does not prioritize these agents in any order of importance or likelihood of use. Subsequent installments of this document will address additional agents with bioterrorism potential, including those that cause tularemia, brucellosis, Q fever, viral hemorrhagic fevers, and viral encephalitis, and disease associated with staphylococcal enterotoxin B.

#### **C. Detection of Outbreaks Caused by Agents of Bioterrorism**

Bioterrorism may occur as covert events, in which persons are unknowingly exposed and an outbreak is suspected only upon recognition of unusual disease clusters or symptoms. Bioterrorism may also occur as announced events, in which persons are warned that an exposure has occurred. SCOR's Bioterrorism Readiness Plan include management of both types of scenarios: suspicion of a bioterrorism outbreak potentially associated with a covert event and announced bioterrorism events or threats.

1. Announced Attack: In an announced attack, persons are warned that an event has occurred.

Notification and preparation should proceed, as per SCOR's Emergency Management Plan, until the attack is ruled as a "hoax" by the proper authorities such as the FBI and state health officials.

- a. The first person notified on the Contact will initiate the internal Emergency Contact Tree.
- b. The designated decontamination area, either of the patient's changing room area, will be prepared for use.
- c. At the time of the activation of the SCOR's Bioterrorism Plan, the Safety Officer or the Clinical Managers or designee will lock all exits and entrances to the SCOR. Staff Members will be required to wear name tags or carry cards identifying themselves as staff members.
- d. All remaining surgeries and procedures will be canceled until authorities rule out the actual attack.
- e. Patient/public informational material and home care instructions for the most likely biological agents to be used in an attack will be available

2. Covert Event/Attack: Event or attack is hidden or unannounced.

3. Syndrome-based criteria

Rapid response to a bioterrorism-related outbreak requires prompt identification of its onset. Because of the rapid progression to illness and potential for dissemination of some of these agents, it may not be practical to await diagnostic laboratory confirmation. Instead, it will be necessary to initiate a response based on the recognition of high-risk syndromes. Each of the agent-specific plans in Section II includes a syndrome description (i.e. typical combination of clinical features of the illness at presentation), that should alert healthcare practitioners to the possibility of a bioterrorism-related outbreak.

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#### 4. Epidemiologic features

Epidemiologic principles must be used to assess whether a patient's presentation is typical of an endemic disease or is an unusual event that should raise concern. Features that should alert SCOR's healthcare providers to the possibility of a bioterrorism-related outbreak include:

- a. A rapidly increasing disease incidence (e.g., within hours or days) in a normally healthy population.
- b. An epidemic curve that rises and falls during a short period of time.
- c. An unusual increase in the number of people seeking care, especially with fever, respiratory, or gastrointestinal complaints.
- d. An endemic disease rapidly emerging at an uncharacteristic time or in an unusual pattern.
- e. Lower attack rates among people who had been indoors, especially in areas with filtered air or closed ventilation systems, compared with people who had been outdoors.
- f. Clusters of patients arriving from a single locale.
- g. Large numbers of rapidly fatal cases. (2)
- h. Any patient presenting with a disease that is relatively uncommon and has bioterrorism potential (e.g., pulmonary anthrax, tularemia, or plague). (3)

#### D. Infection Control Practices for Patient Management

The management of patients following suspected or confirmed bioterrorism events must be well organized and rehearsed. Strong leadership and effective communication are paramount.

##### 1. Isolation precautions

Agents of bioterrorism are generally not transmitted from person to person; re-aerosolization of these agents is unlikely. (4) All patients in healthcare facilities, including symptomatic patients with suspected or confirmed bioterrorism-related illnesses, should be managed utilizing **Standard Precautions**. Standard Precautions are designed to reduce transmission from both recognized and unrecognized sources of infection in healthcare facilities, and are recommended for all patients receiving care, regardless of their diagnosis or presumed infection status. (5) **For certain diseases or syndromes (e.g., smallpox and pneumonic plague), additional precautions may be needed to reduce the likelihood for transmission.** See Section II for specific diseases and requirements for additional isolation precautions.

Standard Precautions prevent direct contact with all body fluids (including blood), secretions, excretions, nonintact skin (including rashes), and mucous membranes. Standard Precautions routinely practiced by healthcare providers include:

##### a. Handwashing

Hands are washed after touching blood, body fluids, excretions, secretions, or items contaminated with such body fluids, whether or not gloves are worn. Hands are washed immediately after gloves are removed, between patient contacts, and as appropriate to

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avoid transfer of microorganisms to other patients and the environment. Either plain or antimicrobial-containing soaps may be used according to SCOR's policy.

b. Gloves

Clean, non-sterile gloves are worn when touching blood, body fluids, excretions, secretions or items contaminated with such body fluids. Clean gloves are put on just before touching mucous membranes and nonintact skin. Gloves are changed between tasks and between procedures on the same patient if contact occurs with contaminated material. Hands are washed promptly after removing gloves and before leaving a patient care area.

c. Masks/Eye Protection or Face Shields

A mask and eye protection (or face shield) are worn to protect mucous membranes of the eyes, nose, and mouth while performing procedures and patient care activities that may cause splashes of blood, body fluids, excretions, or secretions.

d. Gowns

A gown is worn to protect skin and prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, excretions, or secretions. Selection of gowns and gown material should be suitable for the activity and amount of body fluid likely to be encountered. Soiled gowns are removed promptly and hands are washed to avoid transfer of microorganisms to other patients and environments.

2. Patient placement

In small-scale events, routine SCOR's patient placement and infection control practices should be followed. However, when the number of patients presenting to SCOR is too large to allow routine triage and isolation strategies (if required), it will be necessary to apply practical alternatives. These may include cohorting patients who present with similar syndromes, i.e., grouping affected patients into a designated section or area of SCOR. Designated cohorting sites should be chosen in advance by the IC Committee (or other appropriate decision-making body), in consultation with facility maintenance, based on patterns of airflow and ventilation, availability of adequate plumbing and waste disposal, and capacity to safely hold potentially large numbers of patients. The operating room will be the designated cohorting area for airborne or respiratory isolation. The triage or cohort site is the 23hr. unit will have controlled entry to minimize the possibility for transmission to other patients at the facility and to staff members not directly involved in managing the outbreak.

3. Patient transport

Most infections associated with bioterrorism agents cannot be transmitted from patient-to-patient. Patient transport requirements for specific potential agents of bioterrorism are listed in Section II. In general, the transport and movement that is essential to provide patient care, thus reducing the opportunities for transmission of microorganisms within healthcare facilities.

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#### 4. Cleaning, disinfection, and sterilization of equipment and environment

Principles of Standard Precautions should be generally applied for the management of patient-care equipment and environmental control.

- a. SCOR has in place adequate procedures for the routine care, cleaning, and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces and equipment, and should ensure that these procedures are being followed.
- b. SCOR approved germicidal cleaning agents is available in patient care areas to use for cleaning spills of contaminated material and disinfecting non-critical equipment.
- c. Used patient-care equipment soiled or potentially contaminated with blood, body fluids, secretions, or excretions should be handled, cleansed, and disinfected in a manner that prevents exposures to other patients and their environments.
- d. Single-use patient items are appropriately discarded.
- e. Sterilization is required for all instruments or equipment that enters the body or the vascular system.
- f. Rooms and bedside equipment of patients with bioterrorism-related infections should be cleaned using the same procedures that are used for all patients as a component of Standard Precautions, unless the infecting microorganism and the amount of environmental contamination indicate special cleaning. In addition to adequate cleaning, thorough disinfection of bedside equipment and environmental surfaces may be indicated for certain organisms that can survive in the inanimate environment for extended periods of time. Approved cleaning and disinfecting products are used before, during, in-between, and after each patient care episode.
- g. Patient linen should be handled in accordance with Standard Precautions. Although linen may be contaminated, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms to other patients, personnel and environments. Contaminated linen will be placed into the red biohazardous bag, will be picked up by the contracted linen company, transported to their facility for final decontamination and laundering.
- h. Contaminated waste should be sorted and discarded in accordance with federal, state and local regulations.
- i. Policies for the prevention of occupational injury and exposure to bloodborne pathogens in accordance with Standard Precautions and Universal Precautions is in place at SCOR(5).

#### 5. Discharge management

Ideally, patients with bioterrorism-related infections will not be discharged from SCOR until they are deemed noninfectious. However, consideration should be given to developing home-care instructions in the event that large number of persons exposed may preclude admission of all infected patients. Depending on the exposure and illness, home care instructions may include recommendations for the use of appropriate barrier precautions, handwashing, waste management, and cleaning and disinfection of the environment and patient care items.

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#### 6. Handling and care of laboratory specimen

Pathology departments and clinical laboratories should be informed of a potentially infectious outbreak prior to submitting any specimens for examination and disposal. Specimens would be routed to the approved referenced lab, as agreements with local laboratories are Level A, and able to provide minimal identification of agents.

### E. Post Exposure Management

#### 1. Decontamination of Patients and Environment

The need for decontamination depends on the suspected exposure and in most cases will not be necessary. The goal of decontamination after a potential exposure to a bioterrorism agent is to reduce the extent of external contamination of the patient and contain the contamination to prevent further spread. Decontamination should only be considered in instances of gross contamination. Decisions regarding the need for decontamination should be made in consultation with state and local health departments. Decontamination of exposed individuals prior to receiving them in SCOR may be necessary to ensure the safety of patients and staff while providing care. SCOR will refer patient to other available state health department listed locations for patient decontamination prior to SCOR entry.

Depending on the agent, likelihood for re-aerosolization, of a risk associated with cutaneous exposure, clothing of exposed persons may need to be removed. After removal of contaminated clothing, patients should be instructed (or assisted if necessary) to immediately shower with soap and water. **Potentially harmful practices, such as bathing patients with bleach solutions, are unnecessary and should be avoided.** Clean water, saline solution, or commercial ophthalmic solutions are recommended for rinsing eyes. If indicated, after removal at the decontamination site, patient clothing should be handled only by personnel wearing appropriated personal protective equipment, and placed in an impervious bag to prevent further environmental contamination. Decontamination requirements for specific potential agents of bioterrorism are listed in Section II. (6)

Development of Bioterrorism Readiness Plans should include coordination with the FBI field office. The FBI may require collection of exposed clothing and other potential evidence for submission to FBI or Department of Defense laboratories to assist in exposure investigations.

#### 2. Prophylaxis and post-exposure immunization

Recommendations for prophylaxis are subject to change. Current recommendations for post-exposure prophylaxis and immunization are provided in Section II for relevant potential bioterrorism agents. However, up-to-date recommendations should be obtained in consultation with local and state health departments and CDC. SCOR will refer staff members suspected of exposure to infectious patients to Washoe County Health District or to their private healthcare provider for identification and management. In general, maintenance of accurate occupational health records will facilitate identification, contact, assessment, and delivery of post-exposure care to potentially exposed healthcare workers.

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#### 3. Triage and management of large scale exposures and suspected exposures

SCOR does not anticipate to triage and manage large scale exposures and suspected exposures. In the event, SCOR is called upon to assist with this need, SCOR, with the involvement of the IC committee, administration, building maintenance, laboratory directors and nursing directors, will best be able to deliver care by doing the following. SCOR's needs will vary with the size of the regional population served and the proximity to other healthcare facilities and external assistance. Triage and management planning for large-scale events may include, but not limited to:

- a. Establishing networks of communication and lines of authority required to coordinate onsite care of internal and external emergency contacts in coordination with HAVBED state wide emergency system.
- b. Planning for cancellation of non-emergency services and procedures.
- c. Identifying sources able to supply available vaccines, immune globulin, antibiotics, and botulinum anti-toxin (with assistance from local and state health departments 404-639-2206).
- d. Planning for the efficient evaluation and discharge of patients.
- e. Developing discharge instructions for patients determined to be non-contagious or in need of additional on-site care, including details regarding if and when they should return for care or if they should seek medical follow-up.
- f. Determining availability and sources for additional medical equipment and supplies that may be needed for urgent large-scale care.
- g. Planning for the allocation or re-allocation of scarce equipment in the event of a large-scale event.
- h. With recommendation from the consulting Lab Director, identify SCOR's ability to manage a sudden increase in the number of cadavers on site. (3, 7)

#### 4. Psychological aspects of bioterrorism

Following a bioterrorism-related event, fear and panic can be expected from patients, staff members or other healthcare providers. Psychological responses following a bioterrorism event may include horror, anger, panic, unrealistic concerns about infection, fear of contagion, paranoia, social isolation, or demoralization. SCOR will refer to and work with mental health support personnel (e.g., psychiatrists, psychologists, social workers, clergy, and volunteer groups) and assist in their collaboration with emergency response agencies and the media. Local, state, and federal media experts can provide assistance with communications needs to address patient and general public fears:

- a. Minimize panic by clearly explaining risks, offering careful but rapid medical evaluation/treatment, and avoiding unnecessary isolation or quarantine.
- b. Treat anxiety in unexposed persons who are experiencing somatic symptoms (e.g., with reassurance, or diazepam-like anxiolytics as indicated for acute relief of those who do not respond to reassurance).
- c. Consider the following to address healthcare worker fears:

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1. Provide bioterrorism readiness education, including frank discussions of potential risks and plans for protecting healthcare providers.
2. Invite active, voluntary involvement in the bioterrorism readiness planning process.
3. Encourage participation in disaster drills

Fearful or anxious healthcare workers may benefit from their usual sources of social support, or by being asked to fulfill a useful role (e.g., as a volunteer at the triage site).

#### **F. Laboratory Support and Confirmation**

This part of the document is subject to updates due to current work underway to improve the diagnostic capacity of laboratories to isolate and identify these agents. Facilities should work with local, state and federal public health services to tailor diagnostic strategies to specific events. Currently the **Bioterrorism Emergency Number at CDC is at the Emergency Response Office, NCEH, 770-488-7100.**

##### 1. Obtaining diagnostic samples

See specific recommendations for diagnostic sampling for each agent. Sampling should be performed in accordance with Standard Precautions. In all cases suspected bioterrorism, collect an acute phase serum sample to be analyzed, aliquotted, and saved for comparison to a later convalescent serum sample.

##### 2. Laboratory criteria for processing potential bioterrorism agents

To evaluate laboratory capacity in the United States, a proposal is being made to group laboratories into one of four levels, according to their ability to support the diagnostic needs presented by an event. The proposed laboratory levels in the planning states are:

- Level A: Clinical laboratories - minimal identification of agents
- Level B: County/State/ other laboratories – identification , confirmation, susceptibility testing
- Level C: State and other large facility laboratories with advanced capacity for testing – some molecular technologies
- Level D: CDC or select Department of Defense laboratories, such as U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID) – Bio Safety Level (BSL) 3 and 4 labs with special surge capacity and advanced molecular typing techniques.

##### 3. Transport requirements

Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. For specific instructions, contact the **Bioterrorism Emergency Number at the CDC Emergency Response Office,**



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770/488-7100. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

### G. Patient, Visitor, and Public Information

Clear, consistent, understandable information should be provided (e.g., via fact sheets) to patients, visitors, and the general public. During bioterrorism – related outbreaks, visitors may be strictly limited.

The Administrator will establish the method and channels of communications to be used to inform the public. The IC committee and Administration should coordinate with state and local health agencies, local emergency services, and local broadcast media systems to decide how communication and action across agencies will be accomplished. The SCOR will abide by the decisions made by authorized health agencies on this matter. Failure to provide a public forum for information exchange may increase anxiety and misunderstanding, increasing fear among individuals who attribute non-specific symptoms to exposure to the bioterrorism agent.

## Section II. Agent-Specific Recommendations

### A. Anthrax

#### 1. Description of Agent/Syndrome

##### a. Etiology

Anthrax is an acute infectious disease caused by *Bacillus anthracis*, a spore forming, and gram-positive bacillus. Associated disease occurs most frequently in sheep, goats, and cattle, which acquire spores through ingestion of contaminated soil. Humans can become infected through skin contact, ingestion, or inhalation of *B. anthracis* spores from infected animals or animal products (as in “wool sorter’s disease” from exposure to goat hair). Person-to-person transmission of inhalational disease does not occur. Direct exposure to vesicle secretions of cutaneous anthrax lesions may result in secondary cutaneous infection. (1)

##### b. Clinical features

Human anthrax infection can occur in three forms: pulmonary, cutaneous, or gastrointestinal, depending on the route of exposure. Of these forms, pulmonary anthrax is associated with bioterrorism exposure to aerosolized spores. (9) Clinical features for each form of anthrax include:

##### Pulmonary

1. Non-specific prodrome of **flu-like symptoms** follows inhalation of infectious spores.
2. Possible brief interim improvement.
3. Two to four days after initial symptoms, **abrupt onset of respiratory failure** and hemodynamic collapse, possibly accompanied by thoracic edema and a **widened mediastinum on chest radiograph** suggestive of mediastinal lymphadenopathy and hemorrhagic mediastinitis.
4. Gram-positive bacilli on blood culture, usually after the first two or three days of illness.

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5. Treatable in early prodromal stage. Mortality remains extremely high despite antibiotic treatment if it is started after the onset of respiratory symptoms.

#### Cutaneous

1. Local skin involvement after direct contact with spores or bacilli.
2. Commonly seen on the head, forearms or hands.
3. Localized itching, followed by a papular lesion that turns vesicular, and within 2-6 days develops into a depressed black eschar.
4. Usually non-fatal if treated with antibiotics.

#### Gastro-intestinal

1. Abdominal pain, nausea, vomiting, and fever following ingestion of contaminated food, usually meat.
2. Bloody diarrhea, hematemesis.
3. Gram-positive bacilli on blood culture, usually after the first two or three days of illness.
4. Usually fatal after progression to toxemia and sepsis. (10)

#### c. Modes of transmission

The spore form of *B. anthracis* is durable. As a bioterrorism agent, it could be delivered as an aerosol. The modes of transmission for anthrax include:

1. Inhalation of spores.
2. Cutaneous contact with spores or spore-contaminated materials.
3. Ingestion of contaminated food. (1)

#### d. Incubation period

The incubation period following exposure to *B. anthracis* ranges from 1 day to 8 weeks (average 5 days), depending on the exposure route and dose:

1. 2 – 60 days following pulmonary exposure.
2. 1 – 7 days following cutaneous exposure.
3. 1 – 7 days following ingestion.

#### e. Period of communicability

Transmission of anthrax infections from person to person is unlikely. Airborne transmission does not occur, but direct contact with skin lesions may result in cutaneous infection. (6)

### 2. Preventive Measures

- a. Vaccine availability: Inactivated, cell-free anthrax vaccine (Bioport Corporation 517/327-1500, formerly Michigan Biologic Products Institute\*) – limited availability.
- b. Immunization recommendations: Routinely administered to military personnel. Routine vaccination of civilian populations not recommended. (1,10,12)

### 3. Infection Control Practices for Patient Management

Symptomatic patients with suspected or confirmed infections with *B. anthracis* should be managed according to current guidelines specific to their disease state. Recommendations for chemotherapy are beyond the scope of this document. For up-to-date information and recommendations for therapy, contact the local and state health department and the Bioterrorism Emergency Number at the CDC Emergency Response Office, 770/488-7100.

- a. Isolation precautions

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Standard Precautions are used for the care of patients with infections associated with *B. anthracis*. Standard Precautions include the routine use of gloves for contact with nonintact skin, including rashes and skin lesions.

b. Patient placement

Private room placement for patients with anthrax is not necessary. Airborne transmission of anthrax does not occur. Skin lesions may be infectious, but requires direct skin contact only.

c. Patient transport

Standard Precautions should be used for transport and movement of patients with *B. anthracis* infections.

d. Cleaning, disinfection, and sterilization of equipment and environment

Principles of Standard Precautions should be generally applied for the management of patient-care equipment and for environmental control (see Section I for more detail).

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\*Use of trade names and commercial sources is for identification only and does not constitute endorsement by CDC or the U.S. Health and Human Services

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e. Discharge management

No special discharge instructions are indicated. Home care providers should be taught to use Standard Precautions for all patient care (e.g., dressing changes).

f. Post-mortem care

Standard Precautions should be used for post-mortem care. Standard Precautions include wearing appropriate personal protective equipment, including masks and eye protection, when generation of aerosols or splatter of body fluids is anticipated.

#### 4. Post Exposure Management

a. Decontamination of patients/environment

The risk of re-aerosolization of *B. anthracis* spores appears to be extremely low in settings where spores were released intentionally or were present at low or high levels. In situations where the threat of gross exposure to *B. anthracis* spores exists cleansing of skin and potentially contaminated fomites (e.g. clothing or environmental surfaces may be considered to reduce the risk for cutaneous and gastrointestinal forms of disease. The plan for decontaminating patients exposed to anthrax may include the following:

1. Instructing patients to remove contaminated clothing and store in labeled, plastic bags.
2. Handling clothing minimally to avoid agitation.
3. Instructing patients to shower thoroughly with soap and water (and providing assistance if necessary).
4. Instructing personnel regarding Standard Precautions and wearing appropriate barriers (e.g., gloves, gown, and respiratory protection) when handling contaminated clothing or other contaminated fomites.

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5. Decontaminating environmental surfaces using EPA-registered, facility-approved sporicidal/germicidal agent or 0.5% hypochlorite solution (one part household bleach added to nine parts water).
- b. Prophylaxis and post-exposure immunization  
Recommendations for prophylaxis are subject to change. Up-to-date recommendations should be obtained in consultation with local and state health departments and CDC. Prophylaxis should be initiated upon confirmation of an anthrax exposure (Table 1).

Table 1. Recommended post-exposure prophylaxis for exposure to *Bacillus anthracis*

| Antimicrobial agent                                                 | Adults             | Children §                                                 |
|---------------------------------------------------------------------|--------------------|------------------------------------------------------------|
| <b>Oral Fluoroquinolones</b>                                        |                    |                                                            |
| One of the following:                                               |                    |                                                            |
| Ciprofloxacin                                                       | 500 mg twice daily | 20-30 mg per kg of body mass daily, divided into two doses |
| Levofloxacin                                                        | 500 mg once daily  | Not recommended                                            |
| Ofloxacin                                                           | 400 mg twice daily | Not recommended                                            |
| <b>If fluoroquinolones are not Available or are contraindicated</b> |                    |                                                            |
| Doxycycline                                                         | 100mg twice daily  | 5 mg per kg of body mass<br>Per day into two doses         |

§ Pediatric use of fluoroquinolones and tetracyclines is associated with adverse effects that must be weighed against the risk of developing a lethal disease. If *B. anthracis* exposure is confirmed, the organism must be tested for penicillin susceptibility. If susceptible, exposed children may be treated with oral amoxicillin 40mg per kg of body mass per day divided every 8 hours (not to exceed 500mg, three times daily).

Prophylaxis should continue until *B. anthracis* exposure has been excluded. If exposure is confirmed, prophylaxis should continue for 8 weeks. In addition to prophylaxis, post-exposure immunization with an inactivated, cell-free anthrax vaccine is also indicated following anthrax exposure. If available, post-exposure antimicrobial prophylaxis can be reduced to 4 weeks. (1)

- c. Triage and management of large scale exposures / potential exposures  
Advance planning should include identification of:
  1. Sources of prophylactic antibiotics and planning for acquisition on short notice.
  2. Locations, personnel needs and protocols for administering prophylactic post-exposure care to large numbers of potentially exposed individuals.
  3. Means for providing telephone follow-up information and other public communications services.

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See Section I for additional general details regarding planning for large-scale patient management.

#### 5. Laboratory Support and Confirmation

Diagnosis of anthrax is confirmed by aerobic culture performed in a BSL – 2 laboratory.

a. Diagnostic samples- Diagnostic samples to obtain include:

1. Blood cultures.
2. Acute serum for frozen storage
3. Stool culture if gastrointestinal disease is suspected.

b. Laboratory selection -Handling of clinical specimens should be coordinated with local and state health departments, and undertaken in BSL – 2 – or – 3 laboratories. The FBI will coordinate collection of evidence and delivery of forensic specimens to FBI or Department of Defense laboratories.

c. Transport requirements-Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. For specific instructions, contact the **Bioterrorism Emergency Number at the CDC Emergency Response Office, 770/488-7100**. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

#### 6. Patient, Visitor, and Public Information

Fact sheets for distribution should be prepared, including explanation that people recently exposed to *B. anthracis* are not contagious, and antibiotics are available for prophylactic therapy along with the anthrax vaccine. Dosing information and potential side effects should be explained clearly. Decontamination procedures, i.e., showering thoroughly with soap and water; and environmental cleaning, i.e., with 0.5% hypochlorite solution (one part household bleach added to nine parts water), can be described.

### B. Botulism

#### a. Etiology

*Clostridium botulinum* is an anaerobic gram-positive bacillus that produces a potent neurotoxin, botulinum toxin. In humans, botulinum toxin inhibits the release of acetylcholine, resulting in characteristic flaccid paralysis. *C. botulinum* produces spores that are present in soil and marine sediment throughout the world. Foodborne botulism is the most common form of disease in adults. An inhalational form of botulism is also possible. (13) Botulism toxin exposure may occur in both forms as agents of bioterrorism.

#### b. Clinical features

Foodborne botulism is accompanied by gastrointestinal symptoms. Inhalational botulism and foodborne botulism are likely to share other symptoms including:

1. Responsive patient with absence of fever.
2. Symmetric cranial neuropathies (drooping eyelids, weakened jaw clench, difficulty swallowing or speaking).

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3. Blurred vision and diplopia due to extra-ocular muscle palsies.
4. Symmetric descending weakness in a proximal to distal pattern (paralysis of arms first, followed by respiratory muscles, then legs).
5. Respiratory dysfunction from respiratory muscle paralysis or upper airway obstruction due to weakened glottis.
6. No sensory deficits.
- c. Mode of transmission  
Botulinum toxin is generally transmitted by ingestion of toxin-contaminated food. (6)  
Aerosolization of botulinum toxin has been described and may be a mechanism for bioterrorism exposure. (11)
- d. Incubation period
  1. Neurologic symptoms of Foodborne botulism begin 12-36 hours after ingestion.
  2. Neurologic symptoms of inhalational botulism begin 24-72 hours after aerosol exposure.
- e. Period of communicability  
Botulism is not transmitted from person to person. (10)

#### 2. Preventive Measures

- a. Vaccine availability  
The Department of Defense has developed a pentavalent toxoid vaccine. This vaccine is available as an investigational new drug (contact USAMRIID, 301/619-2833).  
Completion of a recommended schedule (0,2,12 weeks) has been shown to induce protective antitoxin levels detectable at 1-year post vaccination.
- b. Immunization recommendations: Routine immunization of the public, including healthcare workers is not recommended. (11)

#### 3. Infection Control Practices for Patient Management

Symptomatic patients with suspected or confirmed botulism should be managed according to current guidelines. (14) Recommendations for therapy are beyond the scope of this document. For up-to-date information and recommendations for therapy, contact CDC or state health department.

- a. Isolation precautions  
Standard Precautions are used for the care of patients with botulism.
- b. Patient placement  
Patient-to-patient transmission of botulism does not occur. Patient room selection and care should be consistent with facility policy.
- c. Patient transport  
Standard Precautions should be used for transport and movement of patients with botulism.
- d. Cleaning, disinfection, and sterilization of equipment and environment.  
Principles of Standard Precautions should be generally applied to the management of patient-care equipment and environmental control (see Section I for more detail).
- e. Discharge management

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No special discharge instructions are indicated.

f. Post-mortem care

Standard precautions should be used for post-mortem care. (5)

#### 4. Post Exposure Management

Suspicion of even single cases of botulism should immediately raise concerns of an outbreak potentially associated with shared contaminated food. In collaboration with CDC and local/state health departments, attempts should be made to locate the contaminated food source and identify other persons who may have been exposed. (13) Any individuals suspected to have been exposed to botulinum toxin should be carefully monitored for evidence of respiratory compromise.

a. Decontamination of patients/environment

Contamination with botulinum toxin does not place persons at risk for dermal exposure or risk associated with re-aerosolization. Therefore, decontamination of patients is not required.

b. Prophylaxis and post-exposure immunization

Trivalent botulinum antitoxin is available by contacting state health departments or by contacting CDC (404-639-2206). This horse serum product had <9% percent rate of hypersensitivity reactions. Skin testing should be performed according to the package insert prior to administration. (14)

c. Triage and management of large-scale exposures / potential exposures.

Patients affected by botulinum toxin are at risk for respiratory dysfunction that may necessitate mechanical ventilation. Ventilatory support is required, on average, for 2 to 3 months before neuromuscular recovery allows unassisted breathing. Large-scale exposures to botulinum toxin may overwhelm an institution's available resources for mechanical ventilation. Sources of auxiliary support and means to transport patients to auxiliary sites, if necessary should be planned in advance with coordination among neighboring facilities. (6,10)

See Section I for additional general details regarding planning for large-scale patient management.

#### 5. Laboratory Support and Confirmation

a. Obtaining diagnostic samples

Routine laboratory tests are of limited value in the diagnosis of botulism. Detection of toxin is possible from serum, stool samples, or gastric secretions. For advice regarding the appropriate diagnostic specimens to obtain, contact state health authorities or CDC (Foodborne and Diarrheal Diseases Branch, 404/639-2206).

b. Laboratory selection

Handling of clinical specimens should be coordinated with local and state health departments. The FBI will coordinate collection of evidence and delivery of forensic specimens to FBI or Department of Defense laboratories.

c. Transport requirements

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Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. For specific instructions, contact the **Bioterrorism Emergency Number at the CDC Emergency Response Office, 770/488-7100**. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

#### 6. Patient, Visitor, and Public Information

Fact sheets for distribution should be prepared, including explanation that people exposed to botulinum toxin are not contagious. A clear description of symptoms including blurred vision, drooping eyelids, and shortness of breath should be provided with instructions to report for evaluation and care if such symptoms develop.

### C. Plague

#### 1. Description of Agent/Syndrome

##### a. Etiology

Plague is an acute bacterial disease caused by the gram-negative bacillus *Yersinia pestis*, which is usually transmitted by infected fleas, resulting in lymphatic and blood infections (bubonic and septicemia plague). A bioterrorism-related outbreak may be expected to be airborne, causing a pulmonary variant, pneumonic plague. (3,10)

##### b. Clinic features

Clinical features of pneumonic plague include:

1. Fever, cough, chest pain.
2. Hemoptysis.
3. Muco-purulent or watery sputum with gram-negative rods on gram stain.
4. Radiographic evidence of bronchopneumonia.

##### c. Modes of transmission

1. Plague is normally transmitted from an infected rodent to man by infected fleas.
2. Bioterrorism-related outbreaks are likely to be transmitted through dispersion of an aerosol.
3. Person-to-person transmission of pneumonic plague is possible via large aerosol droplets. (6)

##### d. Incubation period

The incubation period of plague is normally 2-8 days if due to fleaborne transmission. The incubation period may be shorter for pulmonary exposure (1-3 days). (10)

##### e. Period of communicability

Patients with pneumonic plague may have coughs productive of infectious particle droplets. Droplet precautions, including the use of a mask for patient care, should be implemented until the patient has completed 72 hours of antimicrobial therapy. (3, 6)



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#### 2. Preventive Measures

##### a. Vaccine availability

Formalin-killed vaccine exists for bubonic plague, but has not been proven to be effective for pneumonic plague. It is not currently available in the United States.

##### b. Immunization recommendations

Routine vaccination requires multiple doses given over several weeks and is not recommended for the general population. (3). Post-exposure immunization has no utility.

#### 3. Infection Control Practices for Patient Management

Symptomatic patients with suspected or confirmed plague should be managed according to current guidelines. Recommendations for specific therapy are beyond the scope of this document. For up-to-date information and recommendation for therapy, contact CDC or state health department.

##### a. Isolation precautions

For pneumonic plague, Droplet Precautions should be used in addition to Standard Precautions.

1. Droplet Precautions are used for patients known or suspected to be infected with microorganisms transmitted by large particle droplets, generally larger than 5u in size, that can be generated by the infected patient during coughing, sneezing, talking, or during respiratory-care procedures.

2. Droplet Precautions require healthcare providers and others to wear a surgical-type mask when within 3 feet of the infected patient. Based on local policy, some healthcare facilities require a mask be worn to enter the room of a patient on Droplet Precautions.

3. Droplet Precautions should be maintained until patient has completed 72 hours of antimicrobial therapy.

##### b. Patient placement

Patients suspected or confirmed to have pneumonic plague require Droplet Precautions.

Patient placement recommendations for Droplet Precautions include:

1. Placing infected patient in a private room.

2. Cohort in symptomatic patients with similar symptoms and the same presumptive diagnosis (i.e. pneumonic plague) when private rooms are not available.

3. Maintaining spatial separation of at least 3 feet between infected patients and others when cohorting is not achievable.

4. Avoiding placement of patient requiring Droplet Precautions in the same room with an immunocompromised patient.

Special air handling is not necessary and doors may remain open.

##### c. Patient transport

1. Limit the movement and transport of patients on Droplet Precautions to essential medical purposes only.

2. Minimize dispersal of droplets by placing a surgical-type mask on the patient when transport is necessary. (5,6).

##### d. Cleaning, disinfection, and sterilization of equipment and environment

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Principles of Standard Precautions should be generally applied to the management of patient-care equipment and for environmental control (see Section 1 for more details.) (5)

#### e. Discharge management

Generally, patients with pneumonic plague would not be discharged from a healthcare facility until no longer infectious (completion of 72 hours of antimicrobial therapy) and would require no special discharge instructions. In the event of a large bioterrorism exposure with patients receiving care in their homes, home care providers should be taught to use Standard and Droplet Precautions for all patient care.

#### f. Post-mortem care

Standard Precautions and Droplet Precautions should be used for post-mortem care. (5)

### 4. Post Exposure Management

#### a. Decontamination of patients/environment

The risk for re-aerosolization of *Y. pestis* from contaminated clothing of exposed persons is low. In situations where there may have been gross exposure to *Y. pestis*, decontamination of skin and potentially contaminated fomites (e.g. clothing or environmental surfaces) may be considered to reduce the risk for cutaneous or bubonic forms of the disease. (3)

The plan for decontaminating patients may include:

1. Instructing patients to remove contaminated clothing and storing in labeled, plastic bags.
2. Handling clothing minimally to avoid agitation.
3. Instructing to patients to shower thoroughly with soap and water (and providing assistance if necessary).
4. Instructing personnel regarding Standard Precautions and wearing appropriate barriers (e.g. gloves, gown, face shield) when handling contaminated clothing or other contaminated fomites.
5. Performing environmental surface decontamination using an EPA-registered, facility-approved sporicidal/germicidal agent or 0.5% hypochlorite solution (one part household bleach added to nine parts water). (5,6)

#### b. Prophylaxis

Recommendations for prophylaxis are subject to change. Up-to-date recommendations should be obtained in consultation with local and state health departments and CDC.

Post-exposure prophylaxis should be initiated following confirmed or suspected bioterrorism *Y. pestis* exposure, and for post-exposure management of healthcare workers and others who had unprotected face-to-face contact with symptomatic patients (Table 2).

Table 2. Recommended post-exposure prophylaxis for exposure to *Yersinia pestis*.

| Antimicrobial agent | Adults             | Children§                                                   |
|---------------------|--------------------|-------------------------------------------------------------|
| <b>First choice</b> |                    |                                                             |
| Doxycycline         | 100 mg twice daily | 5 mg per kg of body mass per day<br>divided into two doses. |

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#### 2<sup>nd</sup> choice

Ciprofloxacin

500 mg twice daily

20-30 mg per kg of body mass daily,  
divided into two doses.

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§ Pediatric use of tetracyclines and fluoroquinolones is associated with adverse effects that must be weighed against the risk of developing a lethal disease.

Prophylaxis should continue for 7 days after last known or suspected *Y. pestis* exposure, or until exposure has been excluded. (10).

Facilities should ensure that policies are in place to identify and manage health care workers exposed to infectious patients. In general, maintenance of accurate occupational health records will facilitate identification, contact assessment, and delivery of post-exposure care to potentially exposed healthcare workers. (3, 11, 12)

c. Triage and management of large scale exposures/potential exposures

Advance planning should include identification of sources for appropriate masks to facilitate adherence to Droplet Precautions for potentially large numbers of patients and staff. Instruction and reiteration of requirements for Droplet Precautions (as opposed to Airborne Precautions) will be necessary to promote compliance and minimize fear and panic related to an aerosol exposure.

Advance planning should also include identification of other state health facilities with:

1. Sources of bulk prophylactic antibiotics and planning for acquisition on short notice.
2. Locations, personnel needs, and protocols for administering prophylactic post-exposure care to large numbers of exposed individuals.
3. Means for providing telephone follow-up information and other public communications services.

See Section 1 for additional general details regarding planning for large-scale patient management.

### 7. Laboratory Support and Confirmation

Laboratory confirmation of plague is by standard microbiologic culture, but slow growth and misidentification in automated systems are likely to delay diagnosis, for decisions regarding obtaining and processing diagnostic specimens. Contact state laboratory authorities or CDC.

a. Diagnostic samples to obtain include:

1. Serum for capsular antigen testing.
2. Blood cultures.
3. Sputum or tracheal aspirates for Gram's Wayson's and fluorescent antibody staining.
4. Sputum or tracheal aspirates for culture.

b. Laboratory selection

Handling of clinical specimens should be coordinated with local and state health departments, and undertaken in Bio-Safety Level (BSL) -2 or -3 laboratories. (3) The FBI will coordinate collection of evidence and delivery of forensic specimens to FBI or Department of Defense laboratories.

c. Transport requirements

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Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. For specific instructions, contact the **Bioterrorism Emergency Number at the CDC Emergency Response Office, 770/488/7100**. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

#### 8. Patient, Visitor, and Public Information

Fact sheets for distribution should be prepared, including a clear description of Droplet Precautions, symptoms of plague, and instructions to report for evaluation and care if such symptoms are recognized. The difference between prophylactic antimicrobial therapy and treatment of an actual infection should be clarified. Decontamination by showering thoroughly with soap and water can be recommended.

### D. Smallpox

#### 1. Description of Agent/Syndrome

##### a. Etiology

Smallpox is an acute viral illness caused by the variola virus. (11.) Smallpox is a bioterrorism threat due to its potential to cause severe morbidity in a non-immune population and because it can be transmitted via the airborne route. (10). A single case is considered a public health emergency.

##### b. Clinical features

Acute clinical symptoms of smallpox resemble other acute viral illnesses, such as influenza. Skin lesions appear, quickly progressing from macules to papules to vesicles. Other clinical symptoms to aid in identification of smallpox include:

1. 2-4 day, non-specific **prodrome of fever, myalgias**.
2. Rash most prominent on face and extremities (including palms and soles) in contrast to the truncal distribution of varicella.
3. Rash scabs over in 1-2 weeks.
4. In contrast to the rash of varicella, which arises in "crops" variola rash has a synchronous onset. (10)

##### c. Mode of transmission

Smallpox is transmitted via both large and small respiratory droplets. Patient-to-patient transmission is likely from airborne and droplet exposure, and by contact with skin lesions or secretions. Patients are considered more infectious if coughing or if they have a hemorrhagic form of smallpox.

##### d. Incubation period

The incubation period of smallpox is 7-17 days; the average is 12 days.

Period of communicability

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Unlike varicella, which is contagious before the rash is apparent, patients with smallpox become infectious at the onset of the rash and remain infectious until their scabs separate (approximately 3 weeks). (6, 10)

#### 2. Preventive Measures

##### a. Vaccine availability

A live-virus intradermal vaccination is available for the prevention of smallpox. (12)

##### b. Immunization recommendations

Since the last naturally acquired case of smallpox in the world occurred more than 20 years ago, routine public vaccination has not been recommended. (3) **Vaccination against smallpox does not reliably confer lifelong immunity. Even previously vaccinated persons should be considered susceptible to smallpox.**

#### 3. Infection Control Practices for Patient Management

Symptomatic patients with suspected or confirmed smallpox should be managed according to current guidelines. Recommendations for specific therapy are beyond the scope of this document. For up-to-date information and recommendations for therapy, contact the CDC or state health department.

##### a. Isolation precautions

For patients with suspected or confirmed smallpox, both Airborne and Contact Precautions should be used in addition to Standard Precautions.

1. Airborne Precautions are used for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small particle residue, 5 or smaller in size) of evaporated droplets containing microorganisms that can remain suspected in air and can be widely dispersed by air currents.
2. Airborne Precautions require healthcare providers and others to wear respiratory protection when entering the patient room. (Appropriate respiratory protection is based on facility selection policy; must meet the minimal NIOSH standard for particulate respirators, N95). (5,15)
3. Contact Precautions require healthcare providers and others to:
  - a. Wear clean gloves upon entry into patient room.
  - b. Wear gown for all patient contact and for all contact with the patient's environment. Based on local policy, some healthcare facilities require a gown be worn to enter the room of a patient on Contact Precautions. Gown must be removed before leaving the patient's room.
  - c. Wash hands using an antimicrobial agent.

##### b. Patient placement

Patients suspected or confirmed with smallpox require placement in rooms that meet the ventilation and engineering requirements for Airborne Precautions, which include:

1. Monitored negative air pressure in relation to the corridor and surrounding areas.  
6-12 air exchanges per hour.

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2. Appropriate discharge of air to the outdoors, or monitored high efficiency filtration of air

prior to circulation to other areas in the healthcare facility.

3. A door that must remain closed.

**SCOR plans to transfer of suspected or confirmed smallpox patients to neighboring facilities with appropriate isolation rooms as soon as possible.**

In the event of a large outbreak, patients who have active infections with the same disease (i.e., smallpox) may be cohorted in rooms that meet appropriate ventilation and airflow requirements for Airborne Precautions. (5,6)

c. Patient transport

1. Limit the movement and transport of patients with suspected or confirmed smallpox to essential medical purposes only.

2. When transport is necessary, minimize the dispersal of respiratory droplets by placing a mask on the patient, if possible. (5)

d. Cleaning, disinfection, and sterilization of equipment and environment

A component of Contact Precautions is careful management of potentially contaminated equipment and environmental surfaces.

1. When possible, non-critical patient care equipment should be dedicated to a single patient

(or cohort of patients with the same illness).

2. If use of common items is unavoidable, all potentially contaminated, reusable equipment should not be used for the care of another patient until it has been appropriately cleaned and reprocessed. Policies should be in place and monitored for compliance. (5)

e. Discharge management

In general, patients with smallpox will not be discharged from a healthcare facility until determined they are no longer infectious. Therefore, no special discharge instructions are required.

f. Post-mortem care

Airborne and Contact Precautions should be used for post-mortem care. (5)

#### 4. Post Exposure Management

1. Decontamination of patients/environment

2. Patient decontamination after exposure to smallpox is not indicated.

3. Items potentially contaminated by infectious lesions should be handled using Contact Precautions. (6)

a. Prophylaxis and post-exposure immunization

Recommendations for prophylaxis are subject to change. Up-to-date recommendations should be obtained in consultation with local and state health departments and CDC.

Post-exposure immunization with smallpox vaccine (vaccinia virus) is available and effective. Vaccination alone is recommended if given within 3 days of exposure.

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Passive immunization is also available in the form of vaccinia immune-globulin (VIG) (0.6ml/kg IM). If greater than 3 days has elapsed since exposure, both vaccination and VIG should be given concomitantly with vaccination in these patients. (11)

Following prophylactic care, exposed individuals should be instructed to monitor themselves for development of flu-like symptoms or rash during the incubation period (i.e., for 7 to 17 days after exposure) and immediately report to designated care sites selected to minimize the risk of exposure to others.

Facilities should ensure that policies are in place to identify and manage health care workers exposed to infectious patients. In general, maintenance of accurate occupational health records will facilitate identification, contact, assessment, and delivery of post-exposure care to potentially exposed healthcare workers.

a. Triage and management of large scale exposures / potential exposures

Advance planning must involve IC professionals in cooperation with building maintenance, to identify sites within the facility that can provide necessary parameters for Airborne Precautions. See Section I for additional general details regarding planning for large-scale patient management.

#### 5. Laboratory Support and Confirmation

a. Diagnostic samples to obtain

For decisions regarding obtaining and processing diagnostic specimen contact state laboratory authorities or CDC.

b. Laboratory selection

Handling of clinical specimens must be coordinated with state health departments. CDC, and USAMRIID. Testing can be performed only in BSL – 4 laboratories. (11) The FBI will coordinate collection of evidence and delivery of forensic specimen to FBI or Department of Defense laboratories.

c. Transport requirements

Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. For specific instructions, contact the **Bioterrorism Emergency Number at the CDC Response Office, 770/488-7100**. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

#### 6. Patient, Visitor, and Public Information

Fact sheets for distribution should be prepared, including a clear description of symptoms and where to report for evaluation and care if such symptoms are recognized. Details about the type and duration of isolation should be provided. Vaccination information that details who should receive the vaccine and possible side effects should be provided. Extreme measures such as burning or boiling potentially exposed materials should be discouraged.

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### **Section III. Airborne Hazard**

#### **Policy:**

The SCOR to the best of its ability intends to protect patients, staff and visitors from the effects of an airborne hazard that include contamination by chemical cloud, smoke, or other such pollutants to the extent it becomes a significant threat to life or health.

#### **A. Indications of Airborne Hazard**

1. Strange or pungent odor
2. Irritation of the eyes or throat
3. Smoky haze in building
4. Patients/staff/visitors complaining of nausea or choking
5. Surgery Center of Reno may be notified that there is an outdoor hazard, for example, an accident involving a tanker truck or rail car; or there may be an internal hazard such as a hazardous material spill.

#### **PROCEDURE:**

##### **A. If the source is clearly outside:**

1. Notify 911 of external airborne hazard. Have walk-in traffic from the outside redirected to the designated receiving area located at waiting room area. All doors from SCOR to the outside must be kept closed.
2. Shutdown all air handlers in the SCOR and the entire building including outside air make-up where feasible.
3. The Safety Officer or the Administrator shall lock all entrances, except the entrance to the receiving area.
4. Keep all interior doors leading to the receiving area closed. Post signs restricting entrance to authorized personnel only. Safety Officer or the Administrator may dispatch staff to monitor these doors, if necessary.
5. Communicate with the local authorities in regards to the likely duration of the event.

##### **B. If the source is inside:**

1. Shut down the air handlers for the affected area.
2. Isolate the area by closing doors and fire doors.
3. Communicate with the fire department for assistance, if needed.
4. Evacuate the affected area via routes away from the contamination.
5. If patients/staff/visitors may be exposed to the hazard along the evacuation routes, consider use of masks.



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### SUMMARY: INFECTION CONTROL GUIDELINES FOR POTENTIAL AGENTS OF BIOTERRORISM

| Important Phone Number                                                                                                                                                                           | Bacterial Agents |             |         |          |                |                  |           |         | Viruses  |                           |                    |                         | Biological Toxins |       |                |                      |   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------|---------|----------|----------------|------------------|-----------|---------|----------|---------------------------|--------------------|-------------------------|-------------------|-------|----------------|----------------------|---|
|                                                                                                                                                                                                  | Anthrax          | Brucellosis | Cholera | Glanders | Bubonic Plague | Pneumonic Plague | Tularemia | Q Fever | Smallpox | Venez Equine Encephalitis | Viral Encephalitis | Viral Hemorrhagic Fever | Botulism          | Ricin | T-2 Mycotoxins | Staph. Enterotoxin B |   |
| County Health Dept:<br>775-328-2400<br>CDC Emergency Response:<br>770-488-7100<br>CDC Hospital Infection<br>Program: 404-639-6413<br>USAMRIID:<br>301-619-2833<br>FBI Local Office: 775-328-4000 |                  |             |         |          |                |                  |           |         |          |                           |                    |                         |                   |       |                |                      |   |
| <b>Isolation Precaution</b>                                                                                                                                                                      |                  |             |         |          |                |                  |           |         |          |                           |                    |                         |                   |       |                |                      |   |
| Standard Precautions <sup>1</sup> for all aspects of patient care                                                                                                                                | X                | X           | X       | X        | X              | X                | X         | X       | X        | X                         | X                  | X                       | X                 | X     | X              | X                    | X |
| Contact Precautions                                                                                                                                                                              |                  | X           |         |          |                |                  |           |         | X        |                           |                    | X                       |                   |       |                |                      |   |
| Airborne Precautions                                                                                                                                                                             |                  |             |         |          |                |                  |           |         | X        |                           |                    |                         |                   |       |                |                      |   |
| Use of N95 mask by all individuals entering the room                                                                                                                                             |                  |             |         |          |                |                  |           |         | X        |                           |                    | X <sup>2</sup>          |                   |       |                |                      |   |
| Droplet Precautions                                                                                                                                                                              |                  |             |         |          |                | X                |           |         |          | X                         |                    |                         |                   |       |                |                      |   |
| Wash hands with antimicrobial soap                                                                                                                                                               |                  | X           | X       |          |                |                  |           |         | X        |                           |                    | X                       |                   |       |                |                      |   |
| <b>Patient Placement</b>                                                                                                                                                                         |                  |             |         |          |                |                  |           |         |          |                           |                    |                         |                   |       |                |                      |   |
| No restrictions                                                                                                                                                                                  | X                |             |         |          |                |                  | X         |         |          |                           |                    |                         | X                 | X     | X              | X                    |   |
| Cohort "like" patients when private room available                                                                                                                                               |                  |             | X       |          | X              | X                |           | X       |          |                           | X                  |                         |                   |       |                |                      |   |
| Private Room                                                                                                                                                                                     |                  | X           | X       | X        | X              | X                |           |         | X        | X                         |                    | X                       |                   |       |                |                      |   |
| Negative Pressure                                                                                                                                                                                |                  |             |         |          |                |                  |           |         | X        |                           |                    | X <sup>2</sup>          |                   |       |                |                      |   |
| Door closed at all times                                                                                                                                                                         |                  |             |         |          |                |                  |           |         | X        |                           |                    | X <sup>2</sup>          |                   |       |                |                      |   |
| <b>Patient Transport</b>                                                                                                                                                                         |                  |             |         |          |                |                  |           |         |          |                           |                    |                         |                   |       |                |                      |   |
| No restrictions                                                                                                                                                                                  | X                |             |         |          |                |                  | X         | X       |          |                           | X                  |                         | X                 | X     | X              | X                    |   |
| Limit movement to essential medical purposes only                                                                                                                                                |                  | X           | X       | X        | X              | X                |           |         | X        | X                         |                    | X                       |                   |       |                |                      |   |
| Place mask on patient to minimize dispersal of droplets                                                                                                                                          |                  |             |         | X        |                | X                |           |         | X        | X                         |                    | X <sup>2</sup>          |                   |       |                |                      |   |
| <b>Cleaning, Disinfection of Equipment</b>                                                                                                                                                       |                  |             |         |          |                |                  |           |         |          |                           |                    |                         |                   |       |                |                      |   |
| Routine terminal cleaning of room with hospital-approved disinfectant                                                                                                                            |                  |             | X       | X        |                |                  | X         | X       | X        | X                         | X                  |                         | X                 | X     | X              | X                    |   |

# SURGERY CENTER OF RENO

## Section 8, D-IV B.1 Environment of Care Management Plan

### Policy: Emergency Preparedness Plan

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|                                                        |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|--------------------------------------------------------|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| upon discharge                                         |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Disinfect surfaces with bleach/water sol.1:9 (10% sol) | X | X |   |   | X | X |   |   |   |   |   | X |   |   |   |   |
| Dedicated equipment disinfected prior to leaving room  |   | X |   |   |   |   |   |   | X |   |   | X |   |   |   |   |
| Special linen handling-red bag                         |   |   |   |   |   |   |   |   | X |   |   |   |   |   |   |   |
| Routine medical waste handled per internal policy      | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |

## SUMMARY: INFECTION CONTROL GUIDELINES FOR POTENTIAL AGENTS OF BIOTERRORISM

(continued)

| Important Phone Number                                                                                                                                                                         | Bacterial Agents |             |         |          |                |                  |           |         | Viruses  |                           |                    |                         | Biological Toxins |       |                |                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------|---------|----------|----------------|------------------|-----------|---------|----------|---------------------------|--------------------|-------------------------|-------------------|-------|----------------|----------------------|
|                                                                                                                                                                                                | Anthrax          | Brubefiosis | Cholera | Glanders | Bubonic Plague | Pneumonic Plague | Tularemia | Q Fever | Smallpox | Venez Equire Encephalitis | Viral Encephalitis | Viral Hemorrhagic Fever | Botulism          | Ricin | T-2 Mycoloxins | Slaph. Enterotoxin B |
| County Health Dept:<br>775-328-2400<br>CDC Emergency Response:<br>770-488-7100<br>CDC Hospital Infection<br>Program:404-639-6413<br>USAMRIID:<br>301-619-2833<br>FBI,Local Office:775-825-6600 |                  |             |         |          |                |                  |           |         |          |                           |                    |                         |                   |       |                |                      |
| <b>Discharge Management</b>                                                                                                                                                                    |                  |             |         |          |                |                  |           |         |          |                           |                    |                         |                   |       |                |                      |
| No special discharge instruction necessary                                                                                                                                                     | X                |             | X       | X        |                |                  | X         | X       |          | X                         | X                  |                         | X                 | X     | X              | X                    |
| Home care providers should be taught principles of Standard Precautions                                                                                                                        | X                | X           |         |          | X              | X                |           |         |          |                           |                    | X                       |                   |       |                |                      |
| Patient not discharged from hospital until determined to be no longer infectious                                                                                                               |                  |             |         |          |                | X                |           |         | X        |                           |                    | X                       |                   |       |                |                      |
| Patient generally not discharged until 72 hours of antibiotics completed                                                                                                                       |                  |             |         |          |                | X                |           |         |          |                           |                    |                         |                   |       |                |                      |
| <b>Post-mortem Care</b>                                                                                                                                                                        |                  |             |         |          |                |                  |           |         |          |                           |                    |                         |                   |       |                |                      |
| Follow principles of Standard Precautions                                                                                                                                                      | X                | X           | X       | X        | X              | X                | X         | X       | X        | X                         | X                  | X                       | X                 | X     | X              | X                    |
| Droplet Precautions                                                                                                                                                                            |                  |             |         |          |                | X                |           |         |          |                           |                    |                         |                   |       |                |                      |
| Airborne Precautions                                                                                                                                                                           |                  |             |         |          |                |                  |           |         | X        |                           |                    |                         |                   |       |                |                      |
| Use of N95 mask by all individuals entering the                                                                                                                                                |                  |             |         |          |                |                  |           |         | X        |                           |                    | X2                      |                   |       |                |                      |

## SURGERY CENTER OF RENO

### Section 8, D-IV B.1 Environment of Care Management Plan

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**Revised: 6-08, 8-11**

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|                                                                                    |   |   |   |   |   |   |   |   |   |   |   |    |   |   |   |   |  |
|------------------------------------------------------------------------------------|---|---|---|---|---|---|---|---|---|---|---|----|---|---|---|---|--|
| room                                                                               |   |   |   |   |   |   |   |   |   |   |   |    |   |   |   |   |  |
| Negative Pressure                                                                  |   |   |   |   |   |   |   |   | X |   |   | X2 |   |   |   |   |  |
| Contact Precautions                                                                |   |   |   |   |   |   |   |   | X |   |   | X  |   |   |   |   |  |
| Routine terminal cleaning of room with hospital-approved disinfectant upon autopsy |   | X | X | X |   |   | X | X | X | X | X |    | X | X | X | X |  |
| Disinfect surfaces with bleach/water sol. 1:9 (10% sol.)                           | X |   |   |   | X | X |   |   |   |   |   | X  |   |   |   |   |  |

1.

**STANDARD PRECAUTIONS** prevent direct contact with all body fluids (including blood), secretions, excretions, non-intact skin (including rashes) and mucous membranes. Standard Precautions routine practiced by healthcare providers includes:

Hand washing, gloves when contact with above, mask/eye protections/face shield while performing procedures that cause splash/spray and gowns to protect skin and clothing during procedures.

2.

Certain viruses (LASSA, Congo-Crimean HF, Ebola and Marburg) may be prone to aerosol nosocomial transmission.

Adopted from Journal of Environmental Health, Vol. 62, No. 10, pp. 21-22

### CDC CLASSIFICATIONS FOR BIOLOGICAL AGENTS

#### Category A:

A. Most likely to be utilized due to the potential for high mortality rates and ease of transmission.

1. Anthrax
2. Botulism
3. Plague
4. Smallpox
5. Tularemia
6. Viral Hemorrhagic Fever

#### Category B:

B. Fairly easy to disseminate. Lower mortality rate.

1. Q Fever
2. Brucellosis
3. Glanders
4. Ricin Toxin
5. Staphylococcus enterotoxin B
6. Epsilon Toxin (from Clostridium perfringens)

#### Category C:

C. Less likely for use, however, these are available and easy to produce. High mortality potential.

1. Hantaviruses
2. Nipah Virus

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3. Tickborne hemorrhagic fever viruses
4. Tickborne encephalitis virus
5. Yellow Fever
6. Multidrug resistant tuberculosis

### BIOTERRORISM NOTIFICATION MATRIX

|                                                | Office Phone   | Cell/Pager/After Hours |
|------------------------------------------------|----------------|------------------------|
| <b>Primary</b>                                 |                |                        |
| Administrator – Nic Towle                      | 775-336-6902   | 843-9604               |
| Director PACU/Quality<br>Jennifer Brown RN     | 336-6952       | 771-4212               |
| Medical Director– Daniel Sorenson, MD          |                | 336-8838               |
| Infection Control Nurse – Kara Matter, RN      | 336-6900       |                        |
| OR Manager- Nicole Philo, RN                   | 336-6928       | 997-6415               |
| <b>Secondary</b>                               |                |                        |
| Safety Officer, Rebecca Fisch RN               | 336-6963       | 342-7851               |
| Pharmacy Consultant, Mary Grear, RPh           |                | 702-433-4837           |
| Laboratory/Pathology Director-                 | 775-746-3400   | 746-3400               |
| Healthcare Reit - Security                     | 1-916-662-5533 | 911                    |
| Public Relations Director- Administrator       | 775-336-6902   | 843-9604               |
|                                                |                |                        |
| <b>External (if bioterrorism is suspected)</b> |                |                        |
| Local Law Enforcement                          | 911            |                        |
| Washoe County Emergency Management             | 775-337-5898   |                        |
| FBI Field Offices                              | 775-825-6600   |                        |
|                                                |                |                        |
|                                                |                |                        |
|                                                |                |                        |
|                                                |                |                        |
|                                                |                |                        |

### Reference List

1. Anonymous, Bioterrorism alleging use of anthrax and interim guidelines for management – United States, 1998, MMWR Morb Mortal Wkly Rep 1999;48:69-74
2. Noah DL, Sovel AL, Ostroff SM, Kildew JA. Biological warfare training: infectious disease outbreak differentiation criteria. Mil Med 1998;163:198-201

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3. DOD DFFUaE. NBC Domestic preparedness response workbook.1998.
4. Simon JD. Biological terrorism. JAMA 1997;278:428-30
5. Centers for Disease Control and Prevention, the Hospital Infection Control Practices Advisory Committee (HICPAC). Recommendations for isolation precautions in hospitals. Am J Infect Control 1996;24:24-52
6. American public health association. Control of communicable diseases in man. Washington DC: American public health association;1995.
7. Tucker JB. National health and medical services response to incidents of chemical and biological terrorism. JAMA 1997;278:362-8.
8. Holloway HC, Norwood AE, Fullerton CS, Engel CC Jr, Ursano RJ. The threat of biological weapons. Prophylaxis and mitigation on psychological and social consequences. JAMA 1997;278:425-7.
9. Pile JC, Malone JD, Eitzen EM, Friedlander AM, Anthrax as a potential biological warfare agent, Arch Intern Med 1998;158:429-34
10. Franz D, Jahrling PB, Friedlander AM, McClain DJ, Hoover DL, Bryne WR, et al. Clinical recognition and management of patients exposed to biological warfare agents. JAMA 1997;278:399-411.
11. U.S.Army medical research institute of infectious diseases. Medical management of biological casualties. Fort Detrick:USAMRIID;1998.
12. Anonymous, Drugs and vaccines against biological weapons, Med Lett Drugs Ther 1999; 41:15-6.
13. Shapiro RL, Hatheway C, Becher J, Swerdlow DL. Botulism surveillance and emergency response. JAMA 1997;278:433-5
14. Shapiro RL, Hatheway C, Swerdlow DL. Botulism in the United States: A clinical and epidemiological review. Arch Intern Med 1998;129:221-8.
15. Federal Register. Respiratory protective devices; final rules and notice, 1995.

REFERENCE: AAAHC Standards, *Facilities and Environment*, Section 8, External disaster- Bioterrorism

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#### Who Should Know This Policy

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

## **SURGERY CENTER OF RENO**

**Section 8, D-IV B.1 Environment of Care Management Plan**

**Policy: Emergency Preparedness Plan**

**Subject: Bio-Terrorism, Code Yellow**

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

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

## SURGERY CENTER OF RENO

### Section Appendix Medication Management

#### Policy: Medication Management

#### Subject: Adverse Drug Reaction

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 4-09, 3-10, 3-11, 3-12,  
3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 3-19

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#### **POLICY:**

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

#### *Definition:*

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

#### **PROCEDURE:**

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

---

#### **Who Should Know This Policy**

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

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

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

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

## **SURGERY CENTER OF RENO**

**Section: Appendix OSHA**

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

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

**Effective Date: 2-06**

**Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13,  
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### **Attachment A Methods of Compliance**

#### **A. Universal Blood and Body Fluid Precautions:**

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

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

#### **B. Engineering and Work Practice Controls:**

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

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

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

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

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



## SURGERY CENTER OF RENO

Section: Appendix OSHA

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

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

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 8-18, 3-19

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

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

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

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

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

#### 4. Laundry:

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

#### 5. Environmental Controls:

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

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

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

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

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

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

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

7. Hepatitis B Vaccination:

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

8. Post Exposure Evaluations:

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

1. Post Exposure Evaluation Procedures:

A. First aid. Clean/rinse exposed area.

B. Report incident to supervisor.

C. Supervisor to ask source patient to be tested.

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

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

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

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

2. Workers compensation steps:

a) Depending on severity of injury:

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

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

c) Provide injured worker with information on carrier

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

|                                             |                                                   |
|---------------------------------------------|---------------------------------------------------|
| Party handling workers' compensation claims | <b>ZURICH CLAIMS SERVICES</b>                     |
| Business Address                            | P.O. Box 49547<br>Colorado Springs, CO 80949-9537 |
| Business Phone                              | <b>800-987-3373</b>                               |
| Effective Date                              | 11/17/2018                                        |
| Termination Date                            | 11/17/2019                                        |
| Policy Number                               | WC 005473353-07                                   |
| Employer's FEIN                             | 770615561                                         |

- d) Contact MedHQ to file First Report of Injury

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

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### Who Should Know This Policy

☒ All Employees ☒ Clinical Managers ☒ Administrator ☒ Medical Director

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

☒ Governing Board ☒ Administrator ☒ Medical Director ☒ Clinical Managers

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

Date: \_\_\_\_\_ Employee Signature: \_\_\_\_\_

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

## SURGERY CENTER OF RENO

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

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

**Effective Date:** 2-06

**Review / Revision:** 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 3-19

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### Policy:

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

### Purpose:

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

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

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

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



## SURGERY CENTER OF RENO

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

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

**Effective Date:** 2-06

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

## **SURGERY CENTER OF RENO**

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

**Subject:** Bloodborne Pathogens Exposure Control Plan, Attachment C:

**Determination of Employee's Exposure Category**

**Effective Date:** 2-06

**Review / Revision:** 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13  
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### **Attachment C**

#### **Determination of Employee's Exposure Category**

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

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

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

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

## SURGERY CENTER OF RENO

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

**Subject:** Bloodborne Pathogens Exposure Control Plan, Attachment C:

**Determination of Employee's Exposure Category**

**Effective Date:** 2-06

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

\_\_\_\_\_  
Name of employee (Print), Job Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Director, Clinical Manager or Administrator

\_\_\_\_\_  
Date

## SURGERY CENTER OF RENO

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

Subject: Bloodborne Pathogens Exposure Plan, Attachment D:

Sharps Injury Log

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13, 3-14, 3-15, 3-16, 3-17, 3-18, 3-19

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### Exposure to Blood/Body Fluids

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| Employee:<br>Name, Last: _____ First: _____ Middle: _____<br>Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other Date of Birth: ____ / ____ / ____<br>Work Location: _____<br>Occupation: _____ If occupation is physician, indicate clinical specialty: _____                                                                                                                                                                                                                                                                                                                                       |                                                                                                    |
| <b>Section I – General Exposure Information</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    |
| 1. Date of exposure: ____ / ____ / ____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                    |
| 2. Number of hours on duty: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 3. Time of exposure: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM                 |
| 6. Location where exposure occurred: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. Is exposed person a temp/agency employee? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 7. Type of exposure: (Check all that apply)<br><input type="checkbox"/> 7a. Percutaneous: Did exposure involve a clean, unused needle or sharp object?<br><input type="checkbox"/> Y <input type="checkbox"/> N (If No, complete Q8, Q9, Section II and Section V-XI)<br><input type="checkbox"/> 7b. Mucous membrane (Complete Q8, Q9, Section III and Section V-XI)<br><input type="checkbox"/> 7c. Skin: Was skin intact? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown (If No, complete Q8, Q9, Section III & Section V-XI)<br><input type="checkbox"/> 7d. Bite (Complete Q9 and Section IV-XI) |                                                                                                    |
| 8. Type of fluid/tissue involved in exposure: (Check one)<br><input type="checkbox"/> Blood/blood products<br><input type="checkbox"/> Solutions (IV fluid, irrigation, etc.): (Check one)<br><input type="checkbox"/> Visibly bloody<br><input type="checkbox"/> Not visibly bloody<br><input type="checkbox"/> Tissue<br><input type="checkbox"/> Other (specify): _____<br><input type="checkbox"/> Unknown                                                                                                                                                                                                                                |                                                                                                    |
| If body fluid, indicate one body fluid type:<br><input type="checkbox"/> Amniotic <input type="checkbox"/> Saliva<br><input type="checkbox"/> CSF <input type="checkbox"/> Sputum<br><input type="checkbox"/> Pericardial <input type="checkbox"/> Tears<br><input type="checkbox"/> Peritoneal <input type="checkbox"/> Urine<br><input type="checkbox"/> Pleural <input type="checkbox"/> Feces/stool<br><input type="checkbox"/> Semen <input type="checkbox"/> Other (Specify): _____<br><input type="checkbox"/> Synovial<br><input type="checkbox"/> Vaginal fluid                                                                      |                                                                                                    |
| 9. Body site of exposure: (Check all that apply)<br><input type="checkbox"/> Hand/finger<br><input type="checkbox"/> Eye<br><input type="checkbox"/> Arm <input type="checkbox"/> Foot<br><input type="checkbox"/> Leg <input type="checkbox"/> Mouth<br><input type="checkbox"/> Nose<br><input type="checkbox"/> Other (specify): _____                                                                                                                                                                                                                                                                                                     |                                                                                                    |

## Section II – Percutaneous Injury

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

2. Depth of the injury: (Check one)

- |                                                       |                                                 |
|-------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Superficial, surface scratch | <input type="checkbox"/> Deep puncture or wound |
| <input type="checkbox"/> Moderate, penetrated skin    | <input type="checkbox"/> Unknown                |

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

☐ Device (select one)    ☐ Non-device sharp object (specify): \_\_\_\_\_ ☐ Unknown sharp object

### *Hollow-bore needle*

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

### *Suture needle*

☐ Suture needle

### *Other solid sharps*

- |                                           |                                         |                                                |
|-------------------------------------------|-----------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Bone cutter      | <input type="checkbox"/> Bur            | <input type="checkbox"/> Electrocautery device |
| <input type="checkbox"/> Elevator         | <input type="checkbox"/> Explorer       | <input type="checkbox"/> Extraction forceps    |
| <input type="checkbox"/> File             | <input type="checkbox"/> Lancet         | <input type="checkbox"/> Microtome blade       |
| <input type="checkbox"/> Pin              | <input type="checkbox"/> Razor          | <input type="checkbox"/> Retractor             |
| <input type="checkbox"/> Rod (orthopedic) | <input type="checkbox"/> Scaler/curette | <input type="checkbox"/> Scalpel blade         |
| <input type="checkbox"/> Scissors         | <input type="checkbox"/> Tenaculum      | <input type="checkbox"/> Trocar                |
| <input type="checkbox"/> Wire             |                                         |                                                |

### *Glass*

- |                                         |                                                |                                                        |
|-----------------------------------------|------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Capillary tube | <input type="checkbox"/> Blood collection tube | <input type="checkbox"/> Medication ampule/vial/bottle |
| <input type="checkbox"/> Pipette        | <input type="checkbox"/> Slide                 | <input type="checkbox"/> Specimen/test/vacuum tube     |

### *Plastic*

- |                                         |                                                |                                                    |
|-----------------------------------------|------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Capillary tube | <input type="checkbox"/> Blood collection tube | <input type="checkbox"/> Specimen/test/vacuum tube |
|-----------------------------------------|------------------------------------------------|----------------------------------------------------|

### *Non-sharp safety device*

- |                                                              |                                                     |                                             |
|--------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Blood culture adapter               | <input type="checkbox"/> Catheter securement device | <input type="checkbox"/> IV delivery system |
| <input type="checkbox"/> Other known device (specify): _____ |                                                     |                                             |

4. Manufacturer and Model: \_\_\_\_\_

## Exposure to Blood/Body Fluids

Page 3 of 7

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

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

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

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

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

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

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

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

*Obtaining a blood specimen percutaneously*

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

*Giving a percutaneous injection*

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

*Performing a line related procedure*

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

*Performing surgery/autopsy/other invasive procedure*

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

*Performing a dental procedure*

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

*Handling a specimen*

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

*Other*

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

## Exposure to Blood/Body Fluids

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

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

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

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

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

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

## Exposure to Blood/Body Fluids

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### Section III – Mucous Membrane and/or Skin Exposure

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

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

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

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

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

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

### Section IV – Bite

1. Wound description: (Check one)

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

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

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



## Exposure to Blood/Body Fluids

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

### Section V – Source Information

1. Was the source patient known? ☐ Y ☐ N

2. Was HIV status known at the time of exposure? ☐ Y ☐ N

3. Check the test results for the source patient (P=positive, N=negative, I=indeterminate, U=unknown, R=refused, NT=not tested)

| Hepatitis B    | P | N | I | U | R | NT |
|----------------|---|---|---|---|---|----|
| HBsAg          |   |   |   |   |   |    |
| HBeAg          |   |   |   |   |   |    |
| Total anti-HBc |   |   |   |   |   |    |
| Anti-HBs       |   |   |   |   |   |    |

### Hepatitis C

|                       |  |  |  |  |  |  |
|-----------------------|--|--|--|--|--|--|
| Anti-HCV EIA          |  |  |  |  |  |  |
| Anti-HCV supplemental |  |  |  |  |  |  |
| PCR-HCV RNA           |  |  |  |  |  |  |

### HIV

|                   |  |  |  |  |  |  |
|-------------------|--|--|--|--|--|--|
| EIA, ELISA        |  |  |  |  |  |  |
| Rapid HIV         |  |  |  |  |  |  |
| Confirmatory test |  |  |  |  |  |  |

### Section VI – For HIV Infected Source

1. Stage of disease: (Check one)

- |                                            |                                                          |
|--------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> End-stage AIDS    | <input type="checkbox"/> Other symptomatic HIV, not AIDS |
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> HIV infection, no symptoms      |
| <input type="checkbox"/> Acute HIV illness | <input type="checkbox"/> Unknown                         |

2. Is the source patient taking anti-retroviral drugs? ☐ Y ☐ N ☐ U

2a. If yes, indicate drug(s): \_\_\_\_\_

3. Most recent CD4 count: \_\_\_\_\_ mm<sup>3</sup> Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mo/yr)

4. Viral load: \_\_\_\_\_ copies/ml \_\_\_\_\_ undetectable Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mo/yr)

### Section VII – Initial Care Given to Healthcare Worker

1. HIV postexposure prophylaxis:

Offered? ☐ Y ☐ N ☐ U

Taken: ☐ Y ☐ N ☐ U (If Yes, complete PEP form)

2. HBIG given? ☐ Y ☐ N ☐ U

Date administered: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Hepatitis B vaccine given: ☐ Y ☐ N ☐ U

Date 1<sup>st</sup> dose administered: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Is the HCW pregnant? ☐ Y ☐ N ☐ U

4a. If yes, which trimester? ☐ 1 ☐ 2 ☐ 3 ☐ U

## Exposure to Blood/Body Fluids

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### Section VIII – Baseline Lab Testing

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

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

### Section IX – Follow-up

1. Is it recommended that the HCW return for follow-up of this exposure? ☐ Y ☐ N

1a. If Yes, will follow-up be performed at this facility? ☐ Y ☐ N

### Section X – Narrative

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

### Section XI – Prevention

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

### Custom Fields

| Label | Label |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

### Comments



## SURGERY CENTER OF RENO

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

Subject: Bloodborne Pathogens Exposure Plan, Attachment F:

Consent or Declination for Hepatitis B vaccination

Effective Date: 2-06

Review / Revision: 2-07, 2-08, 2-09, 3-10, 3-11, 3-12, 3-13,  
3-14, 3-15, 3-16, 3-17, 3-18, 3-19

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### Attachment F

#### INFORMED CONSENT FOR HEPATITIS B VACCINE

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

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

---

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

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Department

Date

Site

Lot

Exp

\_\_\_\_\_  
Witness

Given By:

1<sup>st</sup> Dose

2<sup>nd</sup> Dose

3<sup>rd</sup> Dose

\*SITE: #1 = left deltoid

#2 right deltoid

#1 Signature of employee: \_\_\_\_\_

#2 Signature of employee: \_\_\_\_\_

#3 Signature of employee: \_\_\_\_\_

---

**SURGERY CENTER OF RENO**

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

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3-14, 3-15, 3-16, 3-17, 3-18, 3-19**

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**DECLINATION**

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

☐ I decline the Hepatitis B vaccine as I have received the vaccine in the past. I received the vaccine in \_\_\_\_\_ (year).

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

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

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

#### *Maintenance Requirements Testing*

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

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

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

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

#### *Maintenance Requirements Monthly Testing*

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

1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.

2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating.

3) If the engine cannot be operated until the water temperature and the oil pressure have stabilized and then the test shall be terminated before the 30 minute time period expires.

#### *Maintenance Requirements Annual Load Bank Testing*

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

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

#### **Maintenance Requirement 36 Month Load Bank Testing**

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

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

#### **Maintenance Requirements Time Delays**

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

Time Delays should be set as follows:

On start: 1 second minimum

Transfer to emergency: no minimum

Return to normal: 5 minutes minimum

Shutdown: 5 minutes minimum

Transfer switches shall be operated monthly (8.4.6

#### **Maintenance Requirements**

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

#### **Transfer Time**

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

### *Fire Extinguisher*

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



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

PATIENT LABEL

**BRIEF DESCRIPTION** (Attach additional sheet, if needed)

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

A. LOCATION OF INCIDENT: \_\_\_\_\_

Type of Incident (Check only one that most applies)

B. FALLS

☐ Slip/fall ☐ Found on floor ☐ Other

C. MEDICATION VARIANCE

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

D. TREATMENT OR PROCEDURE VARIANCE

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

E. INFECTION SURGERY CENTER

☐ Infection/Nosocomial confirmed

F. EQUIPMENT/PRODUCT-RELATED INCIDENT

☐ Defective ☐ Electrical shock ☐ Improper use ☐ Wrong equipment  
☐ Electrical Problem ☐ Equipment unavailable ☐ Malfunction ☐ Other \_\_\_\_\_

LOT # \_\_\_\_\_

EQUIPMENT TYPE: \_\_\_\_\_ MODEL #: \_\_\_\_\_

MANUFACTURER: \_\_\_\_\_ SERIAL #: \_\_\_\_\_

G. MISCELLANEOUS

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

H. MEDICAL TREATMENT

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

Physician Name: \_\_\_\_\_

☐ Notified Date: \_\_\_\_\_ Time: \_\_\_\_\_

Address: \_\_\_\_\_

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

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

J. RELATED FACTORS (check all that apply)

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

K SEVERITY LEVEL

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

WITNESSES

Name: \_\_\_\_\_ Name: \_\_\_\_\_

EMPLOYEE PREPARING REPORT

Name \_\_\_\_\_ Date/Time: \_\_\_\_\_ Title: \_\_\_\_\_

L. HOW COULD THIS EVENT HAVE BEEN PREVENTED?

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

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

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

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

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

Administrator Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Medical Director: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Governing Board: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Effective as of: \_\_\_\_\_

## Quality Improvement Plan

### SURGERY CENTER OF RENO, LLC

Approved by the Medical Staff

By: \_\_\_\_\_ Dated: \_\_\_\_\_  
Medical Director

Adopted by the Governing Board of Directors

By: \_\_\_\_\_ Dated: \_\_\_\_\_  
President of the Board

# Surgery Center of Reno

## Quality Improvement Plan

### Purpose:

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

QI Indicators to be monitored will include:

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

### Quality Improvement Issues:

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

Routine monitoring will also include:

Emergency Cart / Defibrillator checks

Refrigerator and Fluid warmer temperature checks.

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



TAHOE  
FOREST  
HEALTH  
SYSTEM

Origination Date: 12/2005  
Last Approved: 02/2020  
Last Revised: 02/2020  
Next Review: 02/2021

Department: *Quality Assurance /  
Performance Improvement -  
AQPI*  
Applicabilities: *System*

## Patient Safety Plan, AQPI-02

### PURPOSE:

To develop, implement, and evaluate a patient safety program for the Tahoe Forest Health System which includes Tahoe Forest Hospital (TFH) and Incline Village Community Hospital (IVCH), (hereinafter referred to as the "organization").

The Tahoe Forest Hospital District (TFHD) Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of this Patient Safety Plan that will identify, evaluate, and take appropriate action to prevent unintended patient care outcomes (adverse events), as well as protect the TFHD's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

This policy is integrated with a companion policy, Risk Management Plan AQPI-04.

The Tahoe Forest Hospital District endorses the National Quality Forum set of "34 Safe Practices for Better Healthcare." Further, the District ascribes to the tenets and practices of the High Reliability Organizations and the Just Culture program in the investigation of near-misses, adverse events and unexpected/unintended outcomes.

#### A. SCOPE & APPLICABILITY

1. This is a Health System program empowered and authorized by the Board of Directors of Tahoe Forest Hospital District. Therefore, it applies to all services and sites of care provided by the organization.

#### B. RECITALS

1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.
3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results. Patients

and patient representatives are informed of unexpected/unintended outcomes as described in 4.8.1 below.

## C. AUTHORITY & RESPONSIBILITY

### 1. Governing Body

- a. The Governing Body, through the approval of this document, authorizes a planned and systematic approach to preventing adverse events and implementing a proactive patient safety plan. The Governing Body delegates the implementation and oversight of this program to the Chief Executive Officer (hereinafter referred to as the "Senior Leader") and request that the Medical Staff approve the creation of a Patient Safety Committee. The Medical Staff Quality Committee will serve as the Patient Safety Committee for TFHD and the IVCH Medical Staff Committee will serve as the Patient Safety Committee for IVCH.

### 2. Senior Leader

- a. The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the structures and processes necessary to accomplish this objective. The Senior Leader delegates the day-to-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.

### 3. Medical Staff

- a. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California evidence Code Section 1157 relating to medical professional peer review and for the State of Nevada subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.
- b. The Patient Safety Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from and distribute information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization. The Patient Safety Committee shall recognize and reinforce that the members of the Medical Staff are responsible for making medical treatment recommendations for their patients.

### 4. Management Team

- a. The Management Team, through the Director of Quality and Regulations and Patient Safety Officer, is responsible for the day-to-day implementation and evaluation of the processes and activities of this Patient Safety Plan.

### 5. Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment C)

- a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.

### 6. Patient Safety/Medical Staff Quality Committee

1. The Patient Safety Committee shall:
  1. Receive reports from the Director of Quality and Regulations and/or the Patient Safety

Officer

2. Evaluate actions of the Director of Quality and Regulations and/or Patient Safety Officer in connection with all reports of adverse events, near misses or unexpected/unintended outcomes alleged to have occurred
3. Review and evaluate the quality of measures carried out by the organization to improve the safety of patients who receive treatment in the Health System
4. Make recommendations to the executive committee or governing body of the Health System to reduce the number and severity of adverse events that occur
5. Report quarterly, and as requested, to the executive committee and governing body
6. The Patient Safety Committee members shall include, at least, the following individuals:
  1. Director of Quality and Regulations or the Patient Safety Officer
  2. Members of the Medical Staff
  3. One member of the nursing staff (CNO or designee)
  4. Director of Pharmacy
  5. Medical Director of Quality
  6. Risk Manager
  7. Chief Operating Officer

#### D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
4. Contribute to performance improvement activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes
6. Manage losses, claims or litigation when adverse events occur.
7. Designing or Re-designing Processes
  - a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.
8. Identification of Potential Patient Safety Issues
  - a. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Areas of focus include:
    - i. Processes identified through a review of the literature

- ii. Issues identified during daily safety huddles.
- iii. Issues or risks to the organization identified by the Reliability Management Team, a multidisciplinary team of staff and leadership members trained in the principles of High Reliability Organizations. (HRO).
- iv. Processes identified through the organization's performance improvement program
- v. Processes identified through Safety Risk Management Reports (Event Reporting, AQPI-06) and sentinel events (Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906)
- vi. Processes identified as the result of findings by regulatory and/or accrediting agencies
- vii. The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"
- viii. Adverse events or potential adverse events as described in HSC 1279.1 (Attachment A)
- ix. Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network. (Attachment B)
- x. TFHD specific results from the Safe and Reliable Healthcare Safety Culture Survey (SCOR - Safety, Communication, and Organizational Reliability)

#### 9. Performance Related to Patient Safety

- a. Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety. In addition, the following will be measured:
- b. The perceptions of risk to patients and suggestions for improving care.
  - i. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.
- c. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.
- d. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of the Just Culture.

#### 10. Proactive Risk Assessments

- a. Through implementation of this Patient Safety Plan, and integrated with the Risk Management Plan and other performance improvement processes, the Department of Quality and Regulations will systemically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm. Identified opportunities for improvement will then undergo redesign (as necessary) to mitigate any risks identified. Additionally, the Reliability Management Team (RMT), meets and discusses risks to the organization on a weekly and monthly basis, analyzing and making recommendations for improvement as described herein under "reporting structure." Lastly, a patient safety risk assessment by an external resource will be performed at least every 24-36 months and reported to the organization as described herein under "reporting structure."

#### 11. Responding to Errors

- a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of



the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include disclosure of the incident or error to the patient and/or family (as noted below in 14.a) along with care for the involved caregivers (as noted below in 12.a).

- b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of High Reliability Organizations and Just Culture. Management of these types of errors is described in Sentinel/ Adverse Event/Error or Unanticipated Outcome, AQPI-1906.

#### 12. Supporting Staff Involved in Errors

- a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: (Care for the Caregiver Involved in Sentinel or Adverse Events, AGOV-1602)

#### 13. Educating the Patient on Error Prevention

- a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

#### 14. Informing the Patient of Errors in Care

- a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/families is described in the policy, Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1909.

#### 15. Reporting of Medical Errors

- a. The organization has established mechanisms to report the occurrence of medical errors both internally and externally.
- b. Errors will be reported internally to the appropriate administrative or medical staff entity.
- c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906.

#### 16. Evaluating the Effectiveness of the Program

- 1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.

#### E. Priorities for the 2020 Calendar Year

- 1. Complete the SCOR Culture of Safety Survey and department specific SCOR survey action plans

2. Complete Care for the Caregiver and Response domains for Beta HEART by implementing Peer Support team at TFHD and by completing investigation training and sending additional staff to BETA HEART workshops
3. Utilize implemented surveillance module for case finding for additional safety and quality opportunities
4. Submit patient safety data to CHPSO quarterly for inclusion in reporting and benchmarking
5. Continue with ongoing Patient Safety education through the Pacesetter Monthly Newsletter, weekly Safety Firsts, email updates, and other educational tools
6. Complete a successful hospital accreditation survey (Healthcare Facilities Accreditation Program - HFAP)

## Related Policies/Forms:

[Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906](#); [Event Reporting, AQPI-06](#); [Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1909](#); [Care for the Caregiver Involved in Sentinel or Adverse Events, AGOV-1602](#); [Risk Management Plan AQPI-04](#); The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

All revision dates:

02/2020, 03/2019, 08/2018, 02/2017, 12/2016, 03/2014, 02/2014, 11/2013, 10/2013, 01/2012, 01/2009

## Attachments

[RM/PSO Standard reports and reporting](#)

## Approval Signatures

| Step Description | Approver                            | Date    |
|------------------|-------------------------------------|---------|
|                  | Janet VanGelder: Director           | 02/2020 |
|                  | Dawn Colvin: Patient Safety Officer | 02/2020 |

# UNIVERSITY MEDICAL CENTER PATIENT SAFETY PLAN 2020

## **I. PURPOSE**

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University Medical Center of Southern Nevada (UMCSN) is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

This is achieved through:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Honest and open communication that fosters trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes and performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

## **II. SCOPE OF ACTIVITIES**

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The scope of this Patient Safety Plan is organizational-wide which includes but is not limited to:

- Patient safety
- Visitor safety
- Employee safety

All staff in University Medical Center of Southern Nevada is able to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, UMC has developed this Patient Safety Plan.

The plan focuses on the process and systems rather than the individual, and recognizes both internal and external customers, as well as facilitates the need for analyzing and improving processes. The core principles of this plan include:

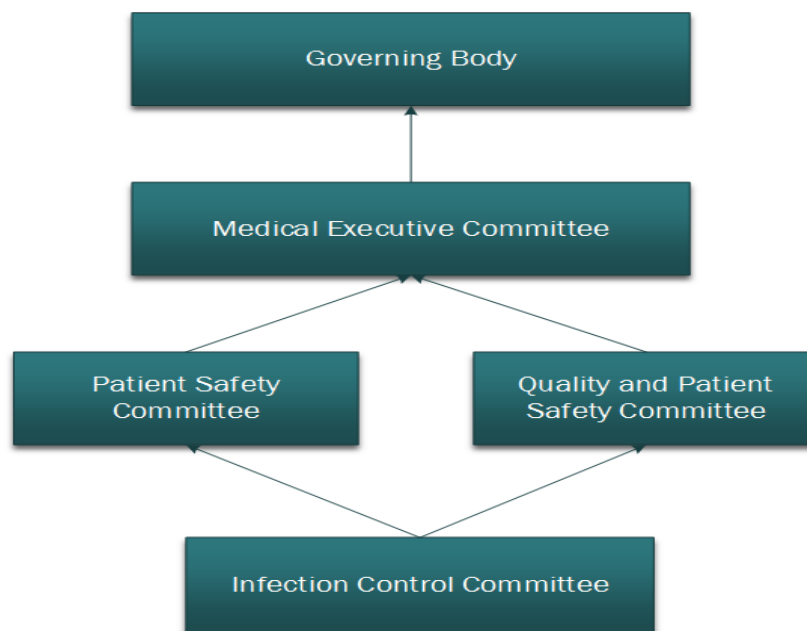
- All staff are encouraged to contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.
- Failure Mode Effect Analysis (FMEA)
- Culture of Safety Survey

### III. ROLES AND RESPONSIBILITIES

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In accordance with [NRS 439.875](#), UMC has established a Patient Safety Committee (PSC). The PSC is responsible to oversee UMC's Patient Safety Program. As directed by the Board of Governors, the Patient Safety Committee will act as the hospital's Grievance Committee.

#### Patient Safety Committee Organization



### Roles and Responsibilities

- In accordance with [NRS 439.875](#), a patient safety committee must be comprised of:
- The infection control officer of the medical facility
- The patient safety officer of the medical facility
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility
- One member of the executive or governing body of the medical facility.

### Patient Safety Committee Responsibilities ([NRS 439.875](#) and [NRS 439.877](#)):

- The Patient Safety Committee will meet at least monthly.
- Receive reports from the patient safety officer pursuant to [NRS 439.870](#).
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment, including the effectiveness of patient identification policy.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar quarter, report to the executive or governing body of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the previous calendar quarter;
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Adopt patient safety checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.
- The Patient Safety Committee shall be responsible for generating, evaluating and reviewing proactive risk assessments for the use of such documents and records in its proceedings. All risk assessments and associated documentation and records shall be subject to the applicable privileges under NRS 49.265 and NRS 439.875 provided that it is generated or produced during the Patient Safety Committee's review process.

#### Patient Safety Officer Responsibilities ( [NRS 439.870](#))

At UMC the Patient Safety Director is designated as the Patient Safety Officer. The Patient Safety Officer shall perform all duties and responsibilities required under Nevada law, including, without limitation:

- Serve on the Patient Safety Committee;
- Supervise the reporting of all sentinel events alleged to have occurred at UMCSN, including without limitation, performing the duties required pursuant to [NRS 439.835](#) ;
- Investigating the occurrence of sentinel events and implementing developed action plans;
- Report to the Patient Safety Committee on actions taken to ensure patient safety.

#### **IV. COMPONENTS AND METHODS**

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##### Reporting of patient safety events:

All medical, nursing and support clinical staff should report any event, situation or circumstance that is significant or potentially significant to patient safety. These events will be reviewed and investigated as needed

This is accomplished by:

- Completing an event report in accordance with UMCSN policy
- Area manager/designee review and completion of the manager's section of the event report
- Quality review by the Center for Quality and Patient Safety
- Review of significant/potentially significant events by the Patient Safety Officer
- Unit review of actual or potential patient safety events with action plans reported through the Patient Safety Committee

##### Mandatory Reporting of Sentinel Events:

Pursuant to [NRS 439.835](#):

- A person who is employed by UMC shall, within 24 hours after becoming aware of a sentinel event, notify the Patient Safety Officer of the event.
- Within 13 days after receiving notification, the patient safety officer shall report the event to the Nevada Division of Public and Behavioral Health (DPBH).
- If the Patient Safety Officer personally discovers or becomes aware of a sentinel event, in the absence of notification by another employee, the patient safety officer shall report the event to DPBH within 14 days of discovery of the event must submit a report to The Health Division.

##### Disclosure of event to patient/family:

Notification of patients who have been involved in a sentinel event will occur no later than 7 days after discovering or becoming aware of an event that occurred at the facility. Serious events should

be disclosed by the attending physician who has responsibility for overall care of the patient. If that is not possible, the Risk Manager or designee will disclose the event to the patient.

Pursuant to [NRS 439.837](#), UMC, upon reporting a sentinel event will conduct an investigation concerning the causes and/or contributing factors of the sentinel event and implement a plan to remedy the causes and/or contributing factors of the sentinel event.

## **Data Collection and Risk Assessment**

Data should drive any quality and patient safety effort. UMC utilizes both internal and external sources for data collection.

### Internal sources include but are not exclusive:

- Patient Safety Reporting system
- Patient and Family complaints
- Risk Management findings
- Morbidity/Mortality reviews
- Infection Control information
- Compliance findings
- Operative/procedural data
- Staff verbal reporting

### External sources include but are not exclusive:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network
- TJC: The Joint Commission
- DPBH: Nevada Division of Public and Behavioral Health

## **V. Patient Safety Checklists and Patient Safety Policies:**

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Patient Safety Checklists must follow protocols, are utilized to improve the health outcomes of patients at UMCSN and include, without limitation:

- Checklists related to specific types of treatment, which include documentation that the treatment provided was properly ordered by the provider of healthcare.
- Checklists to ensuring
- that the patient's room and overall environment is sanitary.
- Checklist for patient discharge that must include: proper instructions concerning prescription medications, aftercare instructions, and any individualized patient instructions.

Patient Safety Policies include, without limitation:

- Appropriate identification of patient prior to providing treatment requiring at least two personal patient identifiers
- Nationally recognized standard precaution protocols, including protocols relating to hand hygiene
- Compliance with the patient safety checklists and patient safety policies

Pursuant to [NRS 439.865](#), Policy # I-270, Patient Safety Checklists and Patient Safety Policies, is an extension of the Patient Safety Plan.

## **VI. Annual Patient Safety Plan and Evaluation:**

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The Patient Safety Officer reviews and updates the Patient Safety Plan annually. The Patient Safety Committee reviews the Patient Safety Plan annually and submits it to the Governing Board.

The Patient Safety Officer prepares a written annual evaluation of the patient safety program. The annual report assesses patient safety events and actions taken to improve patient safety. The report will be submitted through the performance improvement structure and to the Governing Board.

At a minimum, the written report includes the following:

- All system and process failures
- The number and types of sentinel events
- Whether patients and family were notified of events
- All actions taken to improve safety
- All actions taken in response to analyses related to the adequacy of staffing

## **VII. Approval of Patient Safety Plan**

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According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

In compliance with [NRS 439.843](#), on or before March 1 of each year, a copy of the most current patient safety plan established to [NRS 439.865](#) will be submitted to the Division of Public and Behavioral Health.



## Terms and Definitions

**Patient Safety**: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as “a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

[http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick\\_110.pdf](http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf)

### **Sentinel event** ([NRS 439.830](#))

1. Except as otherwise provided in subsection 2, “sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum.

2. If the publication described in subsection 1 is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by [2002 Special Session, 13](#); A [2005, 599](#); [2013, 217](#))

Institute for Healthcare Improvement (IHI) defines **medical harm** as “unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death.”

**Near miss**: An event or a situation that did not produce patient harm because it did not reach the patient, either due to chance or to capture before reaching the patient; or it if it did reach the patient, due to robustness of the patient or to timely intervention (AHRQ)

**Mandatory reporting**: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

## References

- Root Cause Analysis <http://www.patientsafety.va.gov/professionals/onthejob/rca.asp>
- IHI RCA2 <http://www.ihl.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx>
- Framework for Conducting a Root Cause Analysis and Action Plan [https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/rca\\_framework\\_101017.pdf?db=web&hash=B2B439317A20C3D1982F9FBB94E1724B](https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/rca_framework_101017.pdf?db=web&hash=B2B439317A20C3D1982F9FBB94E1724B)
- Title 40 – Public Health and Safety <https://www.leg.state.nv.us/NRS/NRS-439.html>
- UMC Policy # I-270, Patient Safety Checklist and Policies <http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/2ad0126143283b0788257fef0059151e?OpenDocument>
- UMC Infection Prevention/Control Risk Assessment, Plan and Authority Statement <http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/1cac276a9f965cd288258448006a5cd5?OpenDocument>
- UMC Policy # I-69.1, Safety Intelligence (SI) Event Reporting <http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/36e8e8fb7075c641882582d0005ebc81?OpenDocument>
- UMC Patient Complaint and Grievance Process <http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/31334fee7022675a8825812c00596173?OpenDocument&Highlight=0,grievance>
- UMC Just Culture Policy <http://umc-polandproc/pp6.nsf/d948c925637427b9872566260054a8a2/63bfc663d43078b28825850300682e72?OpenDocument>

**Valley Hospital Medical Center**

**Risk Management/  
Patient Safety Plan**

Nevada Acute Care Division

Revised 1/2020

## I. Overview

**Valley Hospital Medical Center** endorses an integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients.

Patient safety is a cornerstone of quality care and is a leadership priority. **Valley Hospital Medical Center** operates as a Patient Safety Organization to further its commitment in promoting patient safety and assuring that **Valley Hospital Medical Center** remains at the forefront in the delivery of safe and effective clinical care. The Member Patient Safety Evaluation System (PSES) is utilized by **Valley Hospital Medical Center** to track safety information, generate Patient Safety Work Product (PSWP) analysis of safety and clinical performance, and promote best practices. This Acute Care Division Risk Management/Patient Safety Plan ("Plan") provides the general framework to identify, manage, reduce, and eliminate patient safety risks.

The Plan identifies the mechanisms to continually assess and improve the patient safety systems at **Valley Hospital Medical Center**. It is our strategy to utilize statistical tools and defined project work to achieve breakthrough gains in patient safety. Performance improvement tools are used in developing and delivering consistent processes and services. The cultural aspect of the Plan is to promote a non-punitive approach to identifying and reporting adverse events. This is consistent with the "Just Culture" concept to promote patient safety practices by instituting a culture of safety and embracing concepts of teamwork and communication.

Most patient safety events are due to a failure of systems; therefore, a systems analysis approach is utilized in evaluations. The goal is to identify and track errors, deficiencies, and problematic trends in order to continuously improve the underlying systems and to intervene as necessary to improve system processes. Although a non-punitive culture is promoted, this approach is balanced by holding caregivers personally responsible for at-risk behaviors and failures to meet the standard of care. When warranted, discipline measures will be initiated as needed consistent with **Valley Hospital Medical Center** policies. **Valley Hospital Medical Center** employees, contractors, vendors, and members of each facility's medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

### GENERAL STATEMENTS ON GOALS AND OBJECTIVES

To support, maintain and enhance the quality of patient care delivered by:

- Systematic and objective monitoring and evaluation of reports of injuries, accidents, patient safety issues, safety hazards, and/or clinical services findings.
- Identification and assessment of general areas of actual or potential risk in the clinical aspects of the delivery of patient care and safety.
- Implementation of appropriate corrective action, to the extent possible, to alleviate and resolve identified problems or concerns with patient safety issues.

- Evaluation and documentation of the effectiveness of actions implemented.
- Aggregation of data/information collected for integration in information management systems and use in managerial decisions and operations.

## II. Mission and Vision

**Valley Hospital Medical Center's** mission, vision and values drive the Plan and serve as the foundation in identifying strategic goals, objectives and priorities. Our mission is to improve patient safety and the quality of health care delivery through the provision of excellence in clinical care while fostering safe care to our communities, that our patients will recommend to their families and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term results. The vision is to be recognized as the provider of choice for healthcare services in the local community where we are trusted by our patients, families and physicians to create a safe, caring and compassionate experience.

In support of our mission, vision, and values, the Plan promotes:

- Collaboration of administrative leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients along with their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Accountability for every healthcare related decision and action based on the level of risk-taking or egregious behavior identified.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure coordination and integration of care across disciplines and specialties.

**Valley Hospital Medical Center** recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the processes and mechanisms that comprise this plan.

## III. ROLES AND RESPONSIBILITIES

### A. Risk Management/Patient Safety Officer

**Valley Hospital Medical Center** has a designated Risk Director/Manager responsible for patient safety risk identification and reduction for their respective facilities. The designated Risk Director/Manager is also the Patient Safety Officer. Each facility is required to submit scheduled reports to the Board of Governors describing risk reduction efforts associated with facility specific, or industry identified risk exposures, including environmental risks and emergency management. Reports are thoroughly reviewed and analyzed by the risk staff to determine effectiveness and follow-through of identified corrective action plans.

The Patient Safety Officer responsibilities based upon [NRS 439.870](#) include:

- Serving on the Patient Safety Committee (PSC)
- Supervising the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to [NRS 439.835](#).
- Taking action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the PSC regarding any action taken in accordance with the responsibilities above.

## **B. Infection Control Officer**

The infection control officer designated for each facility, based on [NRS 439.873](#), responsibilities include:

- Serving on the Patient Safety Committee.
- Monitoring the occurrences of infections at the facility to determine the number and severity of infections.
- Reporting to the PSC concerning the number and severity of infections at the facility each month.
- Taking such action as determined necessary to prevent and control infections alleged to have occurred at the facility.
- Carrying out the provisions of the Infection Control Program adopted pursuant to [NRS 439.865](#) and ensure compliance with the program.

Based on [NRS 439.865](#), the Patient Safety Plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and

- Facility-specific infection control developed under the supervision of a Certified Infection Preventionist.

## C. Patient Safety

**Valley Hospital Medical Center** has an established Patient Safety Council (PSC) to support patient safety activities. The PSC should ensure that its Patient Safety Plan is promoted and executed successfully. **Valley Hospital Medical Center** has also assembled participants to serve in the Member Workforce and to utilize the Member PSES to generate PSWP and exchange analysis and recommendations with the Acute Care PSO Workforce. The main vehicles for these analytic activities occurring within the Member PSES and the member facility Patient Safety Council meetings. The Member PSES is made up of both electronic and physical spaces for the reporting, storing, and generation of PSWP, including secure SharePoint site, and other electronic databases (including but not limited to RiskConnect (STARS) and Midas) to maintain and manage PSWP.

### I. Facility Patient Safety Committee

According to [NRS 439.875](#), a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plans are promoted and executed successfully. Each facility establishes a Patient Safety Committee (PSC) that meets on a regular basis and at least monthly.

#### Membership:

In accordance with [NRS 439.875](#), the committee core membership consists of the following Key Members: (CEO, CNO, Physician, Risk/ Patient Safety Officer, Infection Prevention Nurse, Pharmacy, and Quality). The COO, CMO and Regional CMO attend, as applicable. NRS requires that at least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing, and pharmaceutical staff of the medical facility. In addition, the infection control officer, patient safety officer, and one member of the executive or governing body of the medical facility.

Based on [NAC 439.920](#), a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of: the Patient Safety Officer, at least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and the Chief Executive Officer (CEO) or Chief Financial Officer (CF) of the medical facility.

#### Meetings:

The required members attend the meetings on a monthly basis. If a required member is absent, the facility makes a suitable replacement with someone that has authority to implement actions identified by the PSC.

**Duties and Responsibilities:**

**Valley Hospital Medical Center's** PSC is charged with the assessment and improvement of high-risk processes related to patient safety. This is to be carried out using a four-step methodology.

- **Issue Identification:** The primary issue is the most important risk issue facing the facility and is determined by reviewing the facility's claims history, claims history unique to the facility, patient safety concerns, industry claims, and through discussions with the risk staff. Other issues may be related to process initiatives.
- **Best Practice:** Once identified, the primary issue is dissected to determine its component issues. For each component issue, a best practice is selected. Best practices represent the most appropriate method for performing the delineated process and should not be selected until the PSC is assured that it is truly the "Best Practice."
- **Implementation:** Implementation strategies are those methods used to put the best practices into place. Often this includes revising policies, education, newsletters, phone calls, meetings, formal training, etc. Responsible parties and dates for completion are identified to ensure success.
- **Monitoring and Accountability:** Monitoring is essential to ensure that the strategies identified have been effective. Improvement should be demonstrated statistically whenever possible.

Additional Patient Safety Committee Responsibilities, based upon [NRS 439.875](#) and [NRS 439.877](#), include:

- Monitor and document the effectiveness of the Patient Identification Policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the Patient Safety Checklists and patient safety policies and a summary of the annual review conducted pursuant to [NRS 439.877\(4\)\(b\)](#).
- Receive reports from the Patient Safety Officer pursuant to [NRS 439.870](#).
- Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred.
- The Quality member of the PSC will review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- The Quality member in conjunction with the Infection Control Officer will review and evaluate the quality of measures carried out by the facility to prevent and control infections.



- Make recommendations to the Board of Directors of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the Board of Directors of the facility regarding:
  - (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  - (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and
  - (3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt Patient Safety Checklists and patient safety policies as required by [NRS 439.877](#), review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

In addition to the work done on the primary issue, the PSC is charged with addressing issues identified through claims reporting, Safety Watch Newsletters, The Joint Commission (Sentinel Event Alerts) and others, HRUs and from the TERM evaluation or other surveys, such as the OBHRU Site Assessments. Feedback is provided on an ongoing basis as to the functioning of the Patient Safety Committee.

## **II. Patient Safety Advisories**

When an untoward event occurs at the facility or in the industry, it is important that we respond in a positive manner. Systems that lead to failure at one facility can be assessed at other facilities to avoid the same or similar occurrence. To this end, Safety Watch newsletters are distributed. These alerts detail the circumstances that lead to a negative outcome and the facility is charged with assessment and improvement of their own processes to prevent similar occurrences. In addition, Clinical Risk Alerts and Medication Safety Alerts are also formulated to apprise the facilities of a specific safety issue that needs to be assessed to prevent reoccurrence.

**Valley Hospital Medical Center** is required to address the Safety Watch newsletters, Clinical Risk Alerts and Medication Safety Alerts via their Patient Safety Committee and this is evidenced in their monthly minutes. Responses to the Safety Watch are reviewed for the opportunity to generate a best practice to implement.

## **C. TERM Program**

The facility has utilized its formalized risk management program identified as TERM: the Technical Elements of Risk Management. Each element focuses on a separate

organizational function and details specific strategies for managing risk in these areas. These elements are summarized as follows:

**Element I. Administration of the Risk Management Program:** The tenets outlined in Element 1 lay the foundation for an effective risk management program. The Risk Manager/Director must be seen as a resource to administration, facility, and medical staff. Written plans, goals, and objectives provide a clear vision to meet the purpose of the risk program. Although the TERM program uses the title “Risk Manager,” this applies equally to Risk Directors.

**Element II. Risk Identification:** Risk identification is essential in order to avoid, mitigate, and eliminate risk-generating practices. This Element focuses on those steps taken to identify exposures faced by the facility.

**Element III. Risk Education:** Education is a cornerstone of the TERM program. Risk management education is intended to reduce and eliminate risk-generating practices and to promote best practices that enhance the provision of safe patient care.

**Element IV. Patient Safety Initiative:** Imperative to a comprehensive RM program is one that focuses on the improvement of patient and staff safety through the creation of an environment that maximizes safety and reduces liability claims exposure. The mechanism used to drive the culture of safety is the Patient Safety Committee (PSC). The PSC operates using a four-step process. These steps include: identification of the problem, determining best practice, implementing the recommendations, and monitoring and accountability. Corrective actions are discussed, monitored, and validated by the PSC.

**Element V. Patient Safety Priority: Root Cause Analysis (RCA):** The cornerstones of an effective Patient Safety and Risk Management Program are (i) the performance of a thorough and credible RCA when a serious, sentinel, never event or a significant near miss event occurs; and (ii) implementation of systemic improvements to enhance patient safety and improve healthcare outcomes going forward.

**Element VI. Environment of Care; Safety and Security Programs:** The safety and security programs in the facility serve to protect and preserve both life and property. Areas of safety include licensing, accreditation and federal, state, and local safety practices and programs, including the EPA, TJC, etc.

**Element VII. Claims and Litigation Management:** The risk manager serves as the on-site representative of the insurance program in the management of general and professional claims and litigation.

**Element VIII. Patient Safety Organization (PSO):** Participants of the Member Workforce are expected to perform identified patient safety activities and to be trained in their

responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the Patient Safety and Quality Improvement Act (PSQIA), and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws.

#### **D. MIDAS**

The MIDAS system is the electronic event reporting system utilized by the facilities to report patient and visitor safety events. The risk management module allows for the collection, categorization, and analysis of incident data using electronic reporting functions (Remote Data Entry - RDE). The facility enters incidents into MIDAS through identification of the type of incident and characteristics of the event using risk parameters and outcomes. Additional information can be attributed to a department, physician, or individual, along with further details of the event. This allows the retrieval of information in a variety of ways for analysis and review.

#### **E. Risk Connect (STARS)**

STARS is an integrated claims management program that allows for complete claims management, including extensive analysis of reportable fields associated with reported claims. STARS also provides for the electronic submission of potential claims by user facilities.

Delineation of issues featured in the probable claim module allows for the facility staff to identify causation factors associated with any reported event. The system also provides for the entry of details that will describe the event and liability concerns.

Trending of claim information is performed on a scheduled basis to operations leadership metrics to form strategies on facilitating risk reduction efforts. Previous examples of this function include the formation of an OB HRU and Perioperative concepts. Quarterly reports should be provided by **Valley Hospital Medical Center's** RM to the Governing Board of all claims activities.

#### **F. Event Notification Site**

The Event Notification Site or ENS, is a web-based system that allows for contemporaneous reporting of serious adverse events and key near miss sentinel events to facility and management. The ENS also provides an environment in which stakeholders can post questions and additional information to the facility reporting the event. Updates to the event are reported in real-time to all identified facility and

stakeholders via the ENS. The Risk Management staff reviews each ENS to determine if follow-up is needed; if follow-up is indicated, it is to be completed within 45 days.

### **G. Root Cause Analysis (RCA)**

Pursuant to [NRS 439.837](#), a medical facility shall, upon reporting a sentinel event pursuant to [NRS 439.835](#), conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both of the sentinel event.

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals. Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

It is recommended that The Joint Commission's root cause analysis and actions plan framework table are utilized. It contains analysis questions and guides the organization in the steps of a root cause analysis. Not all of the questions apply to all of the events or cases.

Utilization of the "5 Whys" technique should be used to explore the cause and effect relationship underlying a problem. One can find the root causes by asking "why" no less than five times.

#### **RCA Responsibilities**

- Organize and coordinate the RCA process. For Serious OB events, RCAs are to be done within 72Hrs, or as soon as possible, of the event.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.



#### H. Patient Safety Checklists

By [NRS 439.865](#), the Patient Safety Plan must include the Patient Safety Checklists and Patient Safety Policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The Patient Safety Checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.

- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
  - Proper instructions concerning prescription medications;
  - Instructions concerning aftercare;
  - Any other instructions concerning his or her care upon discharge; and
  - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

(For your reference— a checklist example is shown in **Appendix A.**)

## **I. Patient Safety Policies**

The Patient Safety Policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.
- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

## **J. MEMBER PATIENT SAFETY EVALUATION SYSTEM (PSES)**

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) and its regulations govern the operations and activities of the UHS Acute Care PSO and its Members. This includes assembling a “workforce” of employees, volunteers, trainees, contractors, and other persons who carry out

patient safety activities on behalf of the Members within the Member Patient Safety Evaluation System (“Member PSES”). Participants in the Member Workforce are expected to perform identified patient safety activities and to be well trained in their responsibilities. They must also understand and acknowledge their obligations, including maintaining the confidentiality of PSWP, as required by the PSQIA, and of Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, and other federal and state laws. The Member PSES serves as a means by which patient safety information is collected, maintained, reported, and analyzed for the UHS Acute Care PSO for the purposes of improving patient safety.

## K. Training and Education

Training is essential to successful implementation of the Patient Safety and TERM program. All facility risk managers undergo extensive orientation and education related to Patient Safety, TERM program and other healthcare, risk-related topics. Newly hired Risk Directors/Managers receive both on-site and collaborative corporate-based education and training to afford them the requisite skills to manage their facility assignment. Each Risk Director/Manager is provided a copy of the TERM source documents and other reference materials that guide the risk management function. In addition, formalized supplemental training is provided to all facility risk managers as needed, including quarterly risk management meetings. Risk leadership provides ongoing support and consultation to their assigned facility to facilitate the minimization of liability exposures and enhancement of safe patient care.

The leadership risk management staff provides consultative services to each facility and as members of designated projects. These activities include on-site assistance, research, and consulting from off-site. Examples of designated projects are as follows.

- Facility specific risk Issues
- Safety Watch newsletters
- MIDAS Focus advisories
- Clinical Risk Alerts
- Medication Safety Alerts

## IV. Acute Care Division Patient Safety Priorities, Goals and Objectives for 2020

- Surgical and Procedural Safety:
  - **Wrong Site Surgery (WSS).**
    - **Goal:** A 50% reduction in WSS events for 2020. Ultimately the goal is zero (0).
      - Monitor through Midas event reporting. Report monthly.
  - **Retained Procedural items (RPIs)**

- **Goal:** Prevent RPIs- a 50% reduction in RPIs with harm for 2020. Ultimately the goal for RPIs is 0.
    - Monitor through Midas event reporting. Report monthly.
- **OBHRU:**
  - **Reduction/Elimination of serious harm by reducing the response time to adverse obstetrical bleeding initiative.**
    - **Goal:** As evidenced by:
      - Education Module X: All new hire staff and providers to complete Hemorrhage module within 1st 3 months of employment. All current staff and providers who care for perinatal patients to complete Hemorrhage module every 2 years (even years).
      - Quantification of blood loss will occur at 95% of all deliveries as evidenced by facility results of Power Insights Hemorrhage report/dashboard.
      - All patients will receive POST BIRTH warning signs education for inpatient stay and discharge as evidenced by Power Insights report on education completion.
      - POST BIRTH collaborative benchmarking and assessment data from AWHONN/Premier collaborative.
    - Monitor through Powers Insights QBL compliance report/Midas/ENS/Claims data, GNOSIS results, and facility education reports. Report monthly.
- **CLABSI/CAUTI Initiative**
  - **Goal:** CLABSI and CAUTI will both be reduced to less than the National CMS mean Standardized Infection Ratio (SIR: CLABSI 0.783; CAUTI 0.857) in 2020.
  - Monitor through CDC's National Healthcare Safety Network (NHSN). Report quarterly.
- **Safe Medication Use**
  - Opioid Analgesic Event Reduction Initiative
    - **Goal:** Decrease the number of preventable OIRD events by 10%.
    - Monitor through MIDAS reports, Cerner, ICD-10 Codes, and other intervention data. Report monthly.
- **Reduce Falls and Falls with Injury**



- **Goal:** 10 % overall reduction in the number of falls in the facility by end of 2020.
  - Review of the progressive mobility (PM) documentation in the facility.
  - Correlation of PM documentation and fall incidents.
  - Review of the documentation of PM in the ICU with LOS and length of intubation.
  - Review of documentation of mobility and progression of mobility.
  - Monitor through MIDAS event reporting. Report quarterly.
- **Culture of Safety**
    - **Goal:** 100% of 2020 Patient Safety Plan Priorities will be implemented within the facility.
    - Monitor through MIDAS event reporting with monthly reporting to PSC.

#### **Valley Hospital Medical Center's 2020 Goals**

- Falls Reduction: Goal of 15% Reduction in falls for 2020. There were a total of 215 falls for 2019.
- CAUTI/CLABSI Reduction: Goal of reducing CAUTI/CLABSI by 15% for 2020. There were a total of 9 CAUTIs and 25 CLABSIs for 2019.
- Increase Midas reporting. Goal to reach the UHS reporting benchmark of 6.4%. There were a total of 5542 Midas events placed in 2019 which equaled to 4.43%.

## **V. Monitoring and Accountability**

### **A. Evaluation of TERM Program**

These evaluations consist of both a core risk and clinical risk review. The facility is required to submit a written corrective action plan for noted deficiencies determined during the TERM evaluation. All information is shared with senior staff and monitored through the facility PSC.

### **B. Patient Safety Committee**

As detailed above, each facility is required to post their monthly reports or minutes that details the work conducted by their Patient Safety Committee to the facility PSES site. These are then reviewed and detailed feedback is provided to coach the committee on their form and function.

### **C. Dashboards**

The Risk Management/Patient Safety Dashboard and the Environment of Care Dashboard include multiple indicators to demonstrate the facility's performance as to these markers. These include: event reporting statistics, fall rate including harmful event rate, medication event rate including harmful medication events, timeliness of event review and closure.

## VI. Evaluation/Review:

The risk staff reviews the effectiveness of the Patient Safety/Risk Management Plan to ensure activities are appropriately focused on improving patient safety, decreasing harmful errors, decreasing rate of compensable events, facility risk program consistency/functionality and support of clinical delivery in the field. Evaluation will include the following:

- The culture supports the identification and reporting of “Near Miss” events
- The framework advances a “Just Culture” approach to patient safety
- Accountability is promoted when acts of “human error”, “at risk”, or “reckless behavior” are identified and corrected resulting in a reduction of potential/actual adverse outcomes.
- Comparison of trended incident data to include analysis of performance to stated targets, submission of incident data in compliance to SOX stipulations and review of trended data submitted to the PSC for potential action
- Review of annualized and prior year’s probable claim reports to determine needs for corporate-based projects designed to improve outcomes in an identified service line
- Review of educational products distributed for the concluding operating year that were intended to improve outcomes associated with a particular clinical emphasis
- Review information, analyses and reports from the Acute Care PSO for integration into the Patient Safety Evaluation System.

## VII. Confidentiality

All PSWP reported, stored, or generated in the Member PSES is confidential and privileged under Federal law. The Member PSES will only be accessed by authorized staff. Workforce participants will be trained on policies and procedures governing their patient safety activities and responsibilities. The PSC annually reviews the effectiveness of the Safety Plan to ensure goals and objectives are appropriately focused on improving patient safety.

## VIII. Approval of Patient Safety Plan

According to [NRS 439.865](#), a medical facility shall submit its patient safety plan to the Governing Board of the facility for approval. After a facility’s patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The Patient Safety Plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to [NRS 439.843](#), on or before March 1 of each year, a copy of the most current Patient Safety Plan established to [NRS 439.865](#) must be submitted to the Division of Public and Behavioral Health.

**Appendix A: Checklist Example: Injuries from Falls and Immobility**

| Process Change                                                                                                                                    | In Place | Not Done | Will Adopt | Notes (Responsible & By When?) |
|---------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|------------|--------------------------------|
| Conduct fall and injury risk assessment upon admission                                                                                            |          |          |            |                                |
| Reassess risk daily and with changes in patient condition                                                                                         |          |          |            |                                |
| Implement patient-specific intervention to prevent falls and injury                                                                               |          |          |            |                                |
| Communicate risk across the team; use handoff forms, visual cues, huddles                                                                         |          |          |            |                                |
| Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks(vital signs) |          |          |            |                                |
| Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds               |          |          |            |                                |
| Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives                                                                        |          |          |            |                                |
| Incorporate multidisciplinary input for falls                                                                                                     |          |          |            |                                |
| Prevention from PT, OT, MD, RN and Phar.D.                                                                                                        |          |          |            |                                |

|                                                                                                                                      |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient |  |  |  |  |
| Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls                         |  |  |  |  |

Reference: Checklists to Improve Patient Safety. June 2013. Health Research & Educational Trust.

# ***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 ANNULY 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 INPROVEMENT) 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, 5/16, 4/17, 6/18, 4/19

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
  - 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 (4)
- 3cc Syringes (4)
- 18g Needles
- Recording Paper
- ECG Cable with Electrodes
- Electrode Gel
- Alcohol Preps
- Pacer Cable with Pads
- Micro-Shield Disposable Barrier

***WILDCREEK SURGERY CENTER***

**POLICIES AND PROCEDURES**

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SECTION: N SAFETY

DATE: 11/97, 3/09, 11/11,  
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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 (4)
- Adenosine 6mg (3)
- Amiodarone 450mg (2)
- Lasix 20mg (2)
- Narcan 0.4mg (2)
- Metoprolol 5mg (2)
- Dilantin 100mg (2)
- Benadryl 50mg (2)
- Digoxin 500mcg (2)
- Ativan 2mg-----in med frig

**DRAWER 3**

- Lactated Ringers 1000ml (1)
- 0.9% sodium chloride 1000ml (1)
- 0.9% Sodium Chloride 250ml (2)
- Primary IV Set (2)
- Secondary IV Set (2)
- 3-way Stop Cocks (2)
- Disposable Pressure Infuser
- Dopamine 400mg (1)
- IV Start Kit (4)
  - Razor
  - Tape
  - Gauze 2x2
  - 19g Butterfly
  - 14g Jelco (2)
  - 16g Jelco (2)
  - 18g Jelco (2)
  - 20g Jelco (2)

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

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SECTION: N SAFETY

DATE: 11/97, 3/09, 11/11,  
1/13, 5/16, 4/17, 6/18, 4/19

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

### **DRAWER 4**

- McIntosh #3 & #4 Disposable Laryngoscopes
- Welch-Allyn Illuminator for Laryngoscopes
- Lubricating Jelly+
- 14 fr. Intubating Stylet (2)
- 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



**WILDCREEK SURGERY CENTER**

**POLICIES AND PROCEDURES**

- Betadine
- Gauze 4x4
- Lubricant

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SECTION: N SAFETY

DATE: 11/97, 3/09, 11/11,  
1/13, 5/16, 4/17, 6/18, 4/19

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

**DRAWER 5**

- MALIGNANT HYPERTHERMIA
  - Dantrium Intravenous 20mg (36)
  - Sterile Water for Reconstitution (1000 cc X 4)
  - 3-way Stop Cocks (2)
  - 60 cc Luer Lock Syringe (4)
  - 60 cc Cath Tip Syringe (2)
  - Foley Catheter Kit
  - Zip Locks for Ice
  - Sterile Med Cup (2)

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

| <u>ITEM</u>                      | <u>LOCATION</u>                          |
|----------------------------------|------------------------------------------|
| Cubed Ice                        | Staff Lounge Freezer                     |
| Freeze Packs                     | Refreshment Refrigerator, Recovery Room  |
| NACL Pour Bottles (1000 cc X 2)  | Medication Refrigerator, Nursing Station |
| Normal Saline I.V. (1000 cc X 3) | Medication Refrigerator, Nursing Station |
| Insulin Humulin R (1)            | Medication Refrigerator, Nursing Station |

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

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SECTION: N SAFETY

DATE 11/97, 7/03, 9/14, 3/19

REVIEWED: 3/12, 5/16

### **TITLE: N-30 CRASH CART AND DEFIBRILLATOR CHECK**

POLICY: WILDCREEK SURGERY CENTER WILL MAINTAIN A CRASH CART AND DEFIBRILLATOR IN GOOD WORKING ORDER AT ALL TIMES. THE CRASH CART WILL BE FULLY STOCKED AND AVAILABLE FOR ALL CARDIO-PULMONARY EMERGENCIES IN THE FACILITY. ITEMS FROM THE CRASH CART WILL NOT BE USED IN ROUTINE PATIENT CARE IN ORDER TO ENSURE AVAILABILITY DURING AN EMERGENCY.

#### **PROCEDURE:**

- 1) THE CRASH CART WILL BE KEPT LOCKED DURING HOURS THE CENTER IS NOT IN OPERATION AND UNLOCKED DURING OPERATIONAL HOURS.
- 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
  - 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) TURN THE DIAL TO THE OFF POSITION
  - H) 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.
- 8) CHECK THAT THE EYE WASH STATION IS FUNCTIONING.
- 9) CHECK THE DRUGS FOR EXPIRATION.
- 10) SIGN THE CHECKLIST.
- 11) REPORT ANY VARIANCES TO NURSE MANAGER.

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***WILDCREEK SURGERY CENTER***

**POLICIES AND PROCEDURES**

SECTION: N SAFETY

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TITLE: **N-30 CRASH CART AND DEFIBRILLATOR CHECK**

- 12) IF THE CART WAS LEFT UNLOCKED, 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 BULB)
- 13) NOTHING IS TO BE PLACED IN OR ON THE CRASH CART THAT IS NOT ON THE APPROVED CONTENTS LIST.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

SECTION: N SAFETY

DATE: 11/97, 9/99, 7/03, 5/16, 1/17  
REVIEWED: 3/13, 4/19

TITLE: **N-40 MALIGNANT HYPERTHERMIA**

PROCEDURE:

1. MALIGNANT HYPERTHERMIA SUPPLIES ARE STORED IN THE BOTTOM DRAWER OF THE CRASH CART AND CHECKED DAILY AS PART OF THE CRASH CART PROCEDURE. MHAUS POSTERS WILL BE MAINTAINED AT THE CRASH CART AND IN BOTH SURGICAL SUITES.
2. SUPPLIES REQUIRING REFRIGERATION ARE STORED IN THE MEDICATION REFRIGERATOR AT THE NURSES STATION AND IN THE BREAK ROOM FREEZER
3. PATIENTS RECEIVING **MH** TRIGGERING AGENTS (SUCCINYLCHOLINE/INHALATION AGENTS) WILL BE OBSERVED FOR THE SIGNS AND SYMPTOMS OF **MH** BY ANESTHESIOLOGIST, OR AND PACU NURSING STAFF.
4. PATIENTS RECEIVING GENERAL ANESTHESIA WILL BE SCREENED FOR HISTORY OF **MH** BOTH SELF AND FAMILY. IN THE PRESENCE OF A POSITIVE HISTORY THE PROCEDURE WILL BE CANCELLED AND RESCHEDULE AT AN INPATIENT FACILITY.

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

- \*\*INTENSE MUSCLE RIGIDITY (USUALLY MASSETER MUSCLE FIRST)  
CAN INVOLVE ENTIRE BODY.
  - \*\*RAPID INCREASE IN END TIDAL 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 ANESTHESIOLOGIST WILL STOP ANESTHESIA. **(MHAUS GUIDELINES WILL BE FOLLOWED)**

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# ***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 ANESTHESIOLOGIST WILL HYPERVENTILATE THE PATIENT WITH 100% O2 AT A FLOW OF 8-10 LITERS/MIN
10. 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.
11. COOLING OF THE PATIENT WILL BE INITIATED:
  - A. IVICED 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. TRANSFER ARRANGEMENTS TO HOSPITAL OF THE PHYSICIAN'S CHOICE.
  - B. AMBULANCE ARRANGEMENTS

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### **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

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

15. THE CIRCULATING NURSE AND/OR ASSIGNED STAFF MEMBER WILL ASSIST THE ANESTHESIOLOGIST IN INSERTING AND SECURING MONITORING LINES: 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

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TITLE: **N-40 MALIGNANT HYPERTHERMIA**

2) AVAILABLE STAFF:

A) BRINGS CRASH CART/M.H. CART TO DESIGNATED AREA

B) PACU STAFF WILL BRING INSULIN TO AREA

C) ICED SALINE AND FREEZE PACKS WILL BE OBTAINED FROM EMPLOYEE LOUNGE FREEZER AND BROUGHT TO AREA.

D) CRUSHED ICE WILL BE OBTAINED FROM FREEZER IN EMPLOYEE LOUNGE AND BROUGHT TO AREA.

**WILDCREEK SURGERY CENTER**

**POLICIES AND PROCEDURES**

- 3) R.N./CIRCULATOR WILL ASSIGN STAFF TO:
- A) MIX DANTRIUM
  - B) INSERT FOLEY CATHETER-----REMEMBERING TO SAVE FIRST RETURN FOR STAT LAB
  - C) RECORD EVENTS ON CODE BLUE RECORD
  - D) ASSIST ANESTHESIOLOGIST INTUBATION, STARTING LINES, AND/OR LAVAGE.

**MALIGNANT HYPERTHERMIA CART SUPPLIES**

- Dantrium Intravenous 20mg (36)
- Sterile Water for Reconstitution (1000 cc X 3)
- IV Administration Set (2)
- Oxygen Mask, Adult, Disposable with 7 Foot Tubing
- 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)

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TITLE: N-40 MALIGNANT HYPERTHERMIA

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

| <u>ITEM</u>                        | <u>LOCATION</u>                        |
|------------------------------------|----------------------------------------|
| Cubed Ice                          | Staff Lounge Freezer                   |
| Freeze Packs (10)                  | Staff lounge freezer, Patient freezer  |
| NACL Pour Bottles<br>(1000 cc X 2) | Medication Refrigerator, Recovery Room |
| Lactated Ringer’s I.V.             | Medication Refrigerator, Recovery Room |

***WILDCREEK SURGERY CENTER***

POLICIES AND PROCEDURES

|                     |                                        |
|---------------------|----------------------------------------|
| (1000 cc X 2)       |                                        |
| Insulin (Humulin R) | Medication Refrigerator, Recovery ROOM |

|                                           |                                                    |
|-------------------------------------------|----------------------------------------------------|
| SECTION: N SAFETY                         | DATE: 11/97, 7/03, 3/10<br>8/12, 11/13, 5/16, 4/19 |
| TITLE: N-50 MANAGEMENT OF A LATEX ALLERGY |                                                    |



# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

**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:

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TITLE: **N-50 MANAGEMENT OF A LATEX ALLERGY**

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- GLOVES-WEAR VINYL GLOVES. WEARING VINYL GLOVES MAY BE ALL THAT IS REQUIRED FOR SOME ALLERGIC REACTIONS.
- MONITORS AND OTHER EQUIPMENT-SOME EQUIPMENT, SUCH AS BLOOD PRESSURE CUFFS AND TUBING AND STETHOSCOPE TUBING MAY CONTAIN LATEX.

B. THE PATIENT SHOULD BE GIVEN AN ALLERGY BAND STATING HIS/HER ALLERGY TO LATEX.

C. A MASTER LIST OF COMMONLY USED LATEX ITEMS WILL BE AVAILABLE TO PERSONNEL RESPONSIBLE FOR THE CARE OF THE LATEX ALLERGY PATIENT.

D. ALL O.R. PERSONNEL CARING FOR THE LATEX ALLERGIC PATIENT PERI-OPERATIVELY WILL ADHERE TO THE GUIDELINES SPECIFIC FOR 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.

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SECTION: N SAFETY

DATE: 11/97, 7/03, 3/10  
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TITLE: N-50 MANAGEMENT OF A LATEX ALLERGY

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

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 COMING INTO CONTACT WITH PATIENT’S ARM.
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.

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SECTION: N SAFETY

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TITLE: N-50 MANAGEMENT OF A LATEX ALLERGY

***WILDCREEK SURGERY CENTER***

**POLICIES AND PROCEDURES**

**LATEX ITEMS:**

- 1. BLADDER AND TUBING IN BLOOD PRESSURE CUFF
- 2. STETHOSCOPES
- 3. STERILE SURGICAL GLOVES

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SECTION: N SAFETY

DATE: 11/97, 7/03, 2/13, 3/12  
REVIEWED: 5/16

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

POLICY:

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

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 A VAILABLE 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 A VAILABLE PACU NURSES WILL RESPOND BRINGING THE CRASH CART WITH DEFIBRILLATOR.
  - ALL A VAILABLE EMPLOYEES AND PHYSICIANS WILL RESPOND AND REMAIN UNTIL IT IS EVIDENT THAT ADEQUATE COVERAGE IS A VAILABLE.
  - ALL INVOLVED PERSONNEL ARE TO RETURN OR REMAIN WITH OTHER PATIENTS OR FAMILIES
  - A WRITTEN DEBRIEFING 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, 5/16

REVIEWED: 3/12

**TITLE: N-60 DEVICE TRACKING**

POLICY: WILDCREEK SURGERY CENTER WILL SUPPORT AND COMPLY WITH THE PROVISIONS SET FORTH BY THE SAFE MEDICAL DEVICES ACT IN REGARD TO TRACKING 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.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **PROCEDURE:**

1. ALL PERMANENTLY IMPLANTABLE DEVICES WILL BE TRACKED. THESE INCLUDE THE FOLLOWING:

- BREAST PROSTHESIS
- EAR PROSTHESIS (DOES NOT INCLUDE MYRINGOTOMY TUBES)
- FINGER IMPLANTS
- HOMOGRAFTS (CORNEA, TYMPANIC MEMBRANE, FASCIA, ETC.)
- HUNTER RODS
- INFUSION PUMPS
- INTRAOCULAR LENS
- AMNIO GRAFTS
- MESH (MARLEX, PROLENE, SURGIPRO, GORETEX, ETC.)
- MOLTENO IMPLANTS
- PLATES
- SPINAL CORD STIMULATORS (PERMANENT)
- TOE IMPLANTS

2. WHEN AN IMPLANT, OTHER THAN AN INTRAOCULAR LENS, IS USED, THE CIRCULATOR WILL PUT IMPLANT INFORMATION (CATALOG #, TYPE AND SERIAL OR LOT NUMBER), AND A REGISTRATION FORM, IF AVAILABLE, IN THE IMPLANT BOOK. IMPLANT INFORMATION IS MARKED RIGHT OR LEFT FOR MAMMARY PROSTHESIS. THE CIRCULATING NURSE WILL SEND THE APPROPRIATE REGISTRATION FORMS TO THE MANUFACTURER.

3. WHEN AN INTRAOCULAR LENS IS USED, THE CIRCULATOR WILL USE THE IOL LOG BOOK FOR PATIENT AND IMPLANT INFORMATION. AN IMPLANT STICKER IS ALSO PLACED ON THE INTRA-OPERATIVE RECORD WHICH IS A PERMANENT PART OF THE PATIENT RECORD. THE IMPLANT BOX CONTAINING THE 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.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

SECTION: N SAFETY

DATE: 11/97, 8/98, 7/03

REVIEWED: 3/12, 5/16

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

**POLICY:** WILDCREEK SURGERY CENTER WILL PROVIDE A SAFE AND HEALTHFUL ENVIRONMENT THROUGHOUT ITS FACILITIES. THE CENTER WILL PROVIDE EXPLICIT GUIDELINES FOR THE PROTECTION OF ALL EMPLOYEES WHO MAY BECOME EXPOSED OR HAVE CONTACT WITH HUMAN BLOOD OR BODY FLUIDS.  
THE CENTER WILL COMPLY WITH ALL RULES, LAWS, REGULATIONS, AND GUIDELINES 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.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- 5) PROCEDURES WILL BE DEVELOPED OR REVISED FOR THE CONTROL OF SPILLS AND PROPER HANDLING AND DISPOSAL METHODS FOR CONTAMINATED CLOTHING AND EQUIPMENT.

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

- 6) EACH MANAGER WILL DEVELOP AND ESTABLISH AN INITIAL AND PERIODIC TRAINING FOR ALL EMPLOYEES WHO PERFORM EXPOSURE CATEGORY I AND II TASKS. NO WORKERS SHOULD ENGAGE IN ANY EXPOSURE I AND II TASKS BEFORE RECEIVING TRAINING PERTAINING TO THE WORK PRACTICES AND PROTECTIVE EQUIPMENT REQUIRED FOR THOSE TASKS
- 7) A POLICY OR SURVEILLANCE WILL BE ESTABLISHED BY THE MANAGER OR APPROPRIATE SUPERVISOR TO ENSURE THAT REQUIRED WORK PRACTICES ARE OBSERVED, AND THAT PROTECTIVE CLOTHING AND EQUIPMENT ARE PROPERLY PROVIDED AND USED.
- 8) ALL KNOWN OR SUSPECTED PENETRATING CONTACTS WILL BE INVESTIGATED TO ESTABLISH THE CONDITIONS SURROUNDING THE EXPOSURE AND TO IMPROVE TRAINING AND WORK PRACTICES OR PROTECTIVE EQUIPMENT TO PREVENT 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 JOBRELATED 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.



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CATEGORY II: TASKS THAT INVOLVE NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES, BUT EMPLOYMENT MAY REQUIRE UNPLANNED CATEGORY I TASKS. THE NORMAL WORK ROUTINE INVOLVES NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES, BUT THE EXPOSURE OR POTENTIAL EXPOSURE MAY BE REQUIRED AS A CONDITION OF EMPLOYMENT.

CATEGORY II PROTECTIVE MEASURES:  
THERE WILL BE READY ACCESS TO APPROPRIATE PROTECTIVE CLOTHING AND EQUIPMENT, (I.E. GLOVES, MASKS, GOWNS, AND EYE SHIELDS) BUT THE CATEGORY II WORKERS NEED NOT WEAR THESE AT ALL TIMES. THEY MUST, HOWEVER, BE PREPARED TO PUT ON PROTECTIVE EQUIPMENT AT ANY TIME AND ON SHORT NOTICE.

CATEGORY III: TASKS THAT INVOLVE NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES. THE TASKS PERFORMED IN CATEGORY I ARE NOT A CONDITION OF EMPLOYMENT. THE NORMAL WORK ROUTINE INVOLVES NO EXPOSURE TO BLOOD, BODY FLUIDS, OR TISSUES. EMPLOYEES WHO PERFORM CATEGORY III TASKS ARE NOT CALLED UPON AS PART OF THEIR JOB TO PERFORM OR ASSIST IN CATEGORY I OR II TASKS. TASKS THAT INVOLVE CASUAL CONTACT (SHAKING HANDS, USING PUBLIC OR SHARED BATHROOMS, OR HANDLING OF PENS AND PENCILS) ARE CATEGORY III TASKS.

PERSONNEL EXPOSURE CATEGORIES:

|                    |                   |                       |
|--------------------|-------------------|-----------------------|
| CATEGORY I:        | CATEGORY II:      | CATEGORY III:         |
| CIRCULATING NURSES | LAUNDRY PERSONNEL | ADMITTING CLERK       |
| SCRUB NURSES       | HOUSEKEEPING      | RECEPTIONIST          |
| SCRUB TECHNICIANS  |                   | BILLING CLERK         |
| INSTRUMENT TECHS   |                   | INSURANCE CLERK       |
| ANESTHESIA AIDES   |                   | MEDICAL RECORDS CLERK |
| PRE-OP NURSES      |                   | SCHEDULING CLERK      |

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**STANDARD OPERATING PROCEDURES:**

|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b><u>CATEGORY I:</u></b>   | 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<br><br>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.                                                                                                 |
| <b><u>CATEGORY II:</u></b>  | 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<br><br>BLOOD, AND ET TUBE<br>CHANGING/REINFORCING<br>HANDLING OF SOILED LINENS,<br><br>BODY FLUIDS, OR TISSUES. THIS INCLUDES ORAL, NASAL SUCTIONING, STARTING/DISCONNECTING IV'S, CHANGING/REINFORCING DRESSINGS, 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. |
| <b><u>CATEGORY III:</u></b> | 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<br><br>TASK.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

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DATE: 11/97, 7/03, 9/04  
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**TITLE: N-80 PATIENT OR VISITOR INCIDENT OR INJURY**

**POLICY:** WILDCREEK SURGERY CENTER WILL OUTLINE PROCEDURES FOR REPORTING UNUSUAL INCIDENTS THAT OCCUR IN OR AROUND THE CENTER AND/OR ANY OF ITS FACILITIES OR PROPERTIES REGARDLESS OF THE DEGREE OF SERIOUSNESS AT THE TIME OF THE OCCURRENCE AS FOLLOWS:

**PROCEDURES:**

- 1) THE CENTER SHALL DOCUMENT ALL UNUSUAL OCCURRENCES.
- 2) EMPLOYEES AND STAFF WILL BE CAUTIONED AGAINST COMMITTING TO THE CENTER'S LIABILITY THROUGH THEIR ACTIONS OR STATEMENTS IN THE PRESENCE OF PATIENTS, VISITORS, OR OTHERS AT ANY TIME.
- 3) ALL VARIANCE INVOLVING PATIENTS WILL BE REPORTED TO THE RISK MANAGEMENT NURSE.
- 4) NO EMPLOYEE SHALL BE TERMINATED FOR AN UNINTENTIONA 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.

# ***WILDCREEK SURGERY CENTER***

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8) EQUIPMENT MALFUNCTION OR EQUIPMENT USER ERROR DURING TREATMENT OR DIAGNOSIS OF A PATIENT THAT DID OR COULD HAVE ADVERSELY AFFECTED THE PATIENT OR PERSONNEL INVOLVED MUST BE REPORTED. VARIANCES THAT REQUIRE REPORTING IN THIS CATEGORY INVOLVE POTENTIAL HARM TO PATIENTS, ACTUAL HARM TO PATIENTS, OR FAILURE TO PROVIDE NEEDED SERVICES ON A TIMELY BASIS TO PATIENTS DUE TO EQUIPMENT MALFUNCTION OR EQUIPMENT USER ERROR.

9) A VARIANCE REPORT MUST BE COMPLETED FOR THE UNSCHEDULED TERMINATION OF ANY SERVICE VITAL TO THE CONTINUED SAFE OPERATION OF THE FACILITY, OR TO THE HEALTH AND SAFETY OF THE STAFF AND PATIENTS. THIS INCLUDES, BUT IS NOT LIMITED TO: TERMINATION OF THE TELEPHONE, ELECTRICITY, GAS, WATER, HEAT, AIR 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.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

16) IN ALL CASES OF MEDICATION LOSS, THE DIRECTOR OF PHARMACY SERVICES  
WILL BE NOTIFIED.

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# ***WILDCREEK SURGERY CENTER***

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**TITLE: N-80 PATIENT OR VISITOR INCIDENT OR INJURY**

**SURGICAL CENTER OWNED ITEMS OR MATERIALS:**

1. NOTIFICATION: WHEN COMPLETING A VARIANCE REPORT OF THIS NATURE THE FOLLOWING INFORMATION SHOULD BE PROVIDED.

A. DESCRIPTION OF ITEM(S) OR MATERIAL(S) INVOLVED

1. MANUFACTURER, OR MANUFACTURER'S SERIAL #
2. ANY OTHER RELATED IDENTIFICATION

ITEM(S) OR B. THE PERSON COMPLETING THE VARIANCE REPORT SHOULD ALSO STATE THE FACTS THAT LET THEM TO BELIEVE IT WAS A POSSIBLE CENTER-OWNED MATERIAL(S) INVOLVED IN THE OCCURRENCE.

C. THE ITEM(S) INVOLVED ARE TO BE IMMEDIATELY REMOVED FROM SERVICE, AND THE DEPARTMENT MANAGER IS TO TAG THE ITEM(S) AS SOON AS POSSIBLE. THE MANAGER OF THE DEPARTMENT INVOLVED IS TO CONTACT THE RISK MANAGEMENT COORDINATOR TO REPORT SUCH OCCURRENCES. THE RISK MANAGER WILL THEN CONTACT THE CENTER'S ADMINISTRATOR FOR FURTHER DIRECTION OR INVOLVEMENT OF THE CENTER'S ATTORNEY IF NECESSARY. FURTHER INVESTIGATION INTO THE MATTER MAY BE ADVISED OR REQUIRED.

D. IF A MEDICAL DEVICE HAS BEEN DETERMINED TO BE A CONTRIBUTING FACTOR IN THE HARMING OF A PATIENT, A REPORT WILL BE FILED IN COMPLIANCE WITH THE "SAFE MEDICAL DEVICE ACT". (REFER TO POLICY N-160)

2. TAGGING:

A. AS SOON AS THE ITEM(S) OR MATERIAL(S) INVOLVED ARE TAKEN OUT OF SERVICE, THE ITEM(S) ARE TO BE TAGGED. THE TAG SHOULD SPECIFY THE FOLLOWING:

1. NAME AND I.D. NUMBER OF PATIENT INVOLVED;
2. DATE OF OCCURRENCE;
3. A LISTING OF ALL PERSONS WHO HAVE HANDLED THE ITEM(S) AFTER THE OCCURRENCE AND THE DATES OF HANDLING.

3. OUTSIDE EXPERTS:

THE ADMINISTRATOR WILL, AT THE DISCRETION OF THE CENTER'S ATTORNEY, DECIDE IF THE ITEM(S) OR MATERIAL(S) SHOULD BE INSPECTED BY OUTSIDE EXPERTS. THE ADMINISTRATOR WILL ARRANGE FOR THE OUTSIDE EXPERT TO CHECK THE ITEM(S) OR MATERIAL(S) IN QUESTION.

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# ***WILDCREEK SURGERY CENTER***

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**TITLE: N-80 PATIENT OR VISITOR INCIDENT OR INJURY**

IF THE ITEM(S) NEED TO BE TRANSPORTED TO THE OUTSIDE EXPERT, THE ADMINISTRATOR WILL BE RESPONSIBLE FOR TRANSPORTATION. THE REPORT OF THIS INVESTIGATION WILL BE FORWARDED TO THE ADMINISTRATOR AND THE CENTER'S ATTORNEY.

**4. PREVENTIVE MAINTENANCE RECORDS AND POLICIES AND PROCEDURES REGARDING THE USE OF ITEMS AND MATERIALS:**

THE ADMINISTRATOR OR DEPARTMENT MANAGER SHOULD SECURE ALL PREVENTIVE MAINTENANCE AND SERVICE RECORDS AS WELL AS SERVICE CONTRACTS ON ALL ITEMS/MATERIALS. A COPY OF THIS INFORMATION WILL BE KEPT ON FILE AND ANY POLICIES AND PROCEDURES REGARDING THE USE OF THESE ITEMS/MATERIALS SHOULD ALSO BE KEPT ON FILE IN THE DEPARTMENT MANAGER'S OFFICE.

**5. ITEMS OR MATERIALS NOT OWNED BY THE CENTER:**

THE  
A. WHEN ANY ITEM(S) OR MATERIAL(S) THAT ARE NO OWNED BY THE CENTER ARE INVOLVED IN AN OCCURRENCE, APPROVAL NEEDS TO BE OBTAINED FROM OWNER OF THE ITEM(S)/ MATERIAL(S) BEFORE THEY CAN BE SENT OUT OR TESTED.

B. IF THERE IS A DISAGREEMENT BETWEEN OWNER OF THE ITEM(S)/MATERIAL(S) AS TO THE TESTING OR PROCEDURE TO BE FOLLOWED, THE ADMINISTRATOR WILL BE CONTACTED.

**6. FOREIGN BODIES:**

WHEN A FOREIGN BODY IS REMOVED FROM A PATIENT AND IT APPEARS THAT IT MAY HAVE BEEN INVOLVED IN AN INJURY TO THE PATIENT, THE SPECIMEN SHOULD BE SENT TO PATHOLOGY ACCORDING TO STANDARD PROCEDURES. A VARIANCE REPORT SHOULD BE WRITTEN ON WHICH IT IS SPECIFIED THAT THE SPECIMEN WAS SENT TO PATHOLOGY AND THE DATE IT WAS SENT. IF NECESSARY, THE NURSING DEPARTMENT MANAGER WILL THEN CONTACT PATHOLOGY SO THAT THE SPECIMEN CAN BE RETAINED.

FOREIGN BODIES WHICH ARE MATERIAL TO CRIMINAL INVESTIGATION WILL BE DIRECTLY TURNED OVER TO THE APPROPRIATE LAW ENFORCEMENT AGENT.

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# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **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.

### **PROCEDURE:**

1. ACCIDENT REPORT: EMPLOYEE'S RESPONSIBILITIES:
  - A. REPORT EVERY ACCIDENT INCURED 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.



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FOLLOWING EXAMINATION BY THE MEDICAL DIRECTOR OR HOUSE  
PHYSICIAN, IF A LIMITED WORK STATUS IS INDICATED, DETERMINE IF SUCH  
WORK IS AVAILABLE FOR THE EMPLOYEE. IF LIMITED WORK IS NOT AVAILABLE,  
CHECK WITH OTHER DEPARTMENT MANAGERS FOR SUCH WORK AND OBTAIN  
THEIR APPROVAL BEFORE OFFERING THE LIMITED WORK TO THE EMPLOYEE.

D. REVIEW THE FORMS AND REPORTS FROM CARE GIVEN TO ENSURE  
APPROPRIATE MEDICAL FOLLOW-UP CARE IS PROVIDED TO THE EMPLOYEE.

E. COORDINATE WITH OTHER DEPARTMENT MANAGERS THE RETURN TO WORK  
STATUS OF INJURED OR ILL EMPLOYEES.

F. REVIEW ALL PAYMENTS, FEES, AND CHARGES FROM LICENSED  
PRACTITIONERS AND OTHER MEDICAL PROVIDERS, AND ASSURE THAT  
THERE ARE MEDICAL REPORTS. SIGN AND SUBMIT RECEIPTS TO THE ACCOUNTS  
PAYABLE DEPARTMENT, AS WELL AS ANY CLAIMS PAID BY THE  
SIIS.

3. MEDICAL DIRECTOR'S RESPONSIBILITIES:

A. EXAMINE AND TREAT OR REFER FOR TREATMENT ALL ON-THE-JOB INJURIES  
INCURRED BY EMPLOYEES. IF THE MEDICAL DIRECTOR IS NOT AVAILABLE,  
THEN THE DESIGNATED HOUSE PHYSICIAN WILL ASSUME THESE  
RESPONSIBILITIES.

B. CONSULT WITH THE DEPARTMENT MANAGER TO DETERMINE "FULL WORK" OR  
"LIMITED WORK" STATUS.

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.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

C. OBTAIN THE NUMBER OF PREVIOUS ACCIDENTS INCURRED BY THIS EMPLOYEE. IF THE NUMBER OF PREVIOUS ACCIDENTS SEEMS TO BE EXCESSIVE, CONSIDER MEDICAL EVALUATION SUCH AS AN EYE EXAMINATION, HEARING TEST, OR A COMPLETE PHYSICAL EXAM, OR EDUCATIONAL COUNSELING TO ELIMINATE FUTURE ACCIDENTS.

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**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.

**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.

***WILDCREEK SURGERY CENTER***

**POLICIES AND PROCEDURES**

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 THIRTY (30) DAYS.

PAGE 3 OF 3

SECTION: N SAFETY

DATE: 10/10, 8/13

REVIEWED: 7/14,

5/16, 6/19

TITLE: N-100 EMERGENCY MANAGEMENT PLAN-DISASTER PREPAREDNESS

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **POLICY:**

THE SURGERY CENTER ACCEPTS THE RESPONSIBILITY TO ESTABLISH A PLAN TO ENSURE THE PROMPT AND EFFECTIVE ACTIONS NECESSARY TO PROTECT PATIENTS, VISITORS, AND STAFF IN THE EVENT OF AN INTERNAL AND/OR EXTERNAL DISASTER. THIS PROTECTION WILL BE PROVIDED BY EMPLOYEES, THE ADT MOTION DETECTOR ALARM, AND LOCAL OFFICIALS. ALL EMPLOYEES WILL ABIDE BY THE FOLLOWING PROCEDURES TO ENSURE THE SAFETY OF ALL PERSONS AT THE CENTER.

### **PROCEDURES:**

THE FACILITY WILL NOT BE A DIRECT PARTICIPANT IN THE COMMUNITY DISASTER PLAN. THE FACILITY WILL NOT BE OPEN 24 HOURS PER DAY AND 7 DAYS PER WEEK. THE FACILITY WILL PROVIDE ASSISTANCE, AS REQUESTED, IN THE FORM OF HEALTHCARE SUPPLIES, EQUIPMENT, AND/OR PERSONNEL TO OTHER HEALTHCARE FACILITIES IN THE COMMUNITY IN THE EVENT OF AN EXTERNAL DISASTER.

AN **INTERNAL DISASTER** IS A SITUATION THAT OCCURS WITHIN THE SURGERY CENTER INTERFERING WITH THE NORMAL OPERATIONS, PRODUCING ACTUAL OR POTENTIAL CASUALTIES AND REQUIRING EMERGENCY ACTION FROM WITHIN OR FROM OUTSIDE TO MINIMIZE DAMAGE.

AN **EXTERNAL DISASTER** IS DEFINED AS ANY INCIDENT OCCURRING IN THE GEOGRAPHICAL AREA SURROUNDING THE SURGERY CENTER, PRODUCING ACTUAL OR POTENTIAL MULTIPLE CASUALTIES, AND/OR CAUSING DAMAGE OR DANGER TO THE CENTER ITSELF.

### **NOTIFICATION:**

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:**

**WILDCREEK SURGERY CENTER**

**POLICIES AND PROCEDURES**

THE FIRST LINE OF AUTHORITY WILL BE THE ADMINISTRATOR. IF THE ADMINISTRATOR IS UNABLE TO PERFORM THIS DUTY, THE DESIGNEE IS THE NURSE MANAGER. TO ENSURE CONTINUOUS LEADERSHIP AND AUTHORITY DURING AN EMERGENCY, THE FOLLOWING IS THE CHAIN OF COMMAND: ADMINISTRATOR, NURSE MANAGER, STAFF REGISTERED NURSES, SURGICAL TECHNICIANS AND BUSINESS STAFF.

**ADMINISTRATOR AND/OR NURSE MANAGER:**

IN THE EVENT OF A DISASTER THE ADMINISTRATOR OR DESIGNEE WILL CONTACT THE LOCAL AUTHORITIES AND A WAIT 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**C 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.

**PATIENT TRANSPORT/ TRANSFER LOG**

**Date:** \_\_\_\_\_ **Transfer Facility:** \_\_\_\_\_

WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

| Patient Name | Physician | Transfer Time | Copy of Chart Sent? | Equipment Sent? Type and Serial # |
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SECTION: N SAFETY  
4/06, 8/19

DATE: 11/97, 7/03,  
  
REVIEWED: 7/14, 5/16

TITLE: N-110 BOMB THREATS, WORKPLACE VIOLENCE

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

**POLICY:** WILDCREEK SURGERY CENTER WILL PROTECT PATIENTS, VISITORS, AND STAFF MEMBERS FROM POSSIBLE HARM INFLICTED BY HOSTILE INDIVIDUALS, ROBBERY ATTEMPTS, OR BOMB THREATS. THIS PROTECTION WILL BE PROVIDED BY EMPLOYEES AND THE ADT MOTION DETECTOR ALARM. ALL EMPLOYEES WILL ABIDE BY THE FOLLOWING PROCEDURES TO ENSURE THE SAFETY OF ALL PERSONS AT THE CENTER.

**PROCEDURE:**

### **BOMB THREAT:**

A BOMB THREAT AGAINST THE CENTER MAY BE RECEIVED BY TELEPHONE, MAIL, OR MESSAGE AT ANY TIME AND IN ANY LOCATION. ALL THREATS SHOULD BE CONSIDERED AS A REAL AND SERIOUS DANGER TO THE LIVES OF PATIENTS, STAFF, AND VISITORS, AND DESTRUCTION OF THE CENTER'S FACILITIES.

### **NOTIFICATION OF A BOMB THREAT:**

- 1) **BY TELEPHONE:** THE PERSON RECEIVING THE CALL SHOULD ATTEMPT TO OBTAIN AS MUCH INFORMATION AS POSSIBLE:
  - EXACT LOCATION OF THE BOMB.
  - TIME SET FOR DETONATION.
  - DESCRIPTION OF EXPLOSIVE CONTAINERS.
  - TYPE OF EXPLOSIVE.
  - REASON FOR CALL OR THREAT.

DURING THE COURSE OF THE CONVERSATION, THE PERSON RECEIVING THE CALL SHOULD WRITE DOWN ALL AVAILABLE INFORMATION. IN ADDITION, THE RECEIVER SHOULD NOTE AS MUCH OF THE FOLLOWING INFORMATION AS POSSIBLE:

- DATE AND TIME CALLED.
- EXACT LANGUAGE USED.
- SEX OF CALLER.
- ESTIMATED AGE OF CALLER.
- PECULIAR OR IDENTIFIABLE ACCENT OF CALLER.
- APPARENT KNOWLEDGE OF THE CENTER BY DESCRIPTION OF LOCATIONS WITHIN THE CENTER.

**TITLE: N-110 BOMB THREATS, WORKPLACE VIOLENCE**

- 2) **BY MAIL OR MESSAGE:** ONCE THE PERSON RECEIVING THE BOMB THREAT RECOGNIZES IT AS SUCH, THIS PERSON WILL NOTIFY THEIR DEPARTMENT MANAGER AND ADMINISTRATOR

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

IMMEDIATELY. DO NOT LEAVE THE LOCATION OF THE RECEIVED THREAT; THE DEPARTMENT MANAGER AND ADMINISTRATOR WILL COME TO THE SITE. NO OTHER PERSONS WILL HANDLE THE PIECE OF MAIL OR MESSAGE, INCLUDING ANY ENVELOPE OR CONTAINER IT MAY HAVE COME IN.

### SEARCH PROCEDURE:

- 1) THE ADMINISTRATOR WILL NOTIFY THE LOCAL POLICE OF THE THREAT RECEIVED BY DIALING 911.
- 2) THE ADMINISTRATOR WILL MAKE THE DECISION OF WHETHER TO:
  - SEARCH THE BUILDING
  - EVACUATE THE PREMISES
- 3) IF A SEARCH IS DECIDED ON, THE DEPARTMENT MANAGER WILL INITIATE THE SEARCH AND ASSIGN MEMBERS TO ASSIST.
- 4) ALL EMPLOYEES SHOULD ACT CALMLY AND QUIETLY DURING THE SEARCH. DO NOT ANNOUNCE OR OTHERWISE ALARM PATIENTS AND VISITORS.
- 5) ALL EMPLOYEES SHOULD MAINTAIN A FAMILIARITY WITH ALL EQUIPMENT, MATERIALS, AND SUPPLIES NORMALLY UTILIZED AT THE CENTER. THIS ALLOWS FOR EASY DETERMINATION OF ITEMS THAT DO NOT BELONG IN THE CENTER WHICH MAY POSSIBLY BE AN EXPLOSIVE DEVICE.
- 6) DURING THE SEARCH, EMPLOYEES SHOULD DIRECT CLOSE ATTENTION TO: STRANGE OR UNFAMILIAR PACKAGES OR SMALL ARTICLES; DOORS TO CABINETS OR CLOSETS WHICH ARE NOT IN THEIR NORMAL POSITION, SUCH AS PARTIALLY OPENED WHEN THEY ARE NORMALLY CLOSED; OR A PIECE OF FURNITURE OR EQUIPMENT NOT IN ITS NORMAL LOCATION.
- 7) UPON DISCOVERY OF ANY OF THE ABOVE SITUATIONS, WILDCREEK SURGERY CENTER PERSONNEL MUST NOT ATTEMPT TO MOVE OR DISTURB ANY ITEM OR ABNORMAL CONDITION FOUND. THEY SHOULD IMMEDIATELY NOTIFY THE ADMINISTRATOR OF THE SITUATION SO THAT QUALIFIED INDIVIDUALS CAN INVESTIGATE THE MATTER.

**TITLE: N-110 BOMB THREATS, WORKPLACE VIOLENCE**

- 8) IF AN EVACUATION OF THE BUILDING IS DECIDED ON, ALL CENTER EMPLOYEES SHOULD FOLLOW THE SAME PLAN AS FOR A FIRE EVACUATION.



# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **RESPONSIBILITIES OF DEPARTMENT MANAGERS:**

- 1) POLICIES OF THEIR RESPECTIVE AREAS AT ALL TIMES. THE IMPORTANCE OF GOOD HOUSEKEEPING AND ORDERLY ARRANGEMENT OF MATERIALS AND SUPPLIES CANNOT BE OVEREMPHASIZED. THIS WILL FACILITATE A THOROUGH AND SPEEDY SEARCH OF THE ENTIRE CENTER.
- 2) ENSURING THAT ALL PERSONNEL WITHIN THEIR RESPECTIVE AREAS ARE FAMILIAR WITH THIS PLAN AND THE IMPORTANCE OF REMAINING CALM WHEN A THREAT IS RECEIVED. THIS IS PARTICULARLY IMPORTANT IN THE PATIENT CARE AREAS.
- 3) UPON NOTIFICATION OF A THREAT, INSTRUCT EACH EMPLOYEE TO SEARCH THEIR IMMEDIATE AREA FOR STRANGE OR UNFAMILIAR OBJECTS OR CONTAINERS.
- 4) EMPLOYEES SHOULD BE INSTRUCTED NOT TO HANDLE OR MOVE ANY SUSPICIOUS OBJECTS OR SITUATIONS.
- 5) PROPER SECURITY OF THEIR AREAS, PARTICULARLY EXTERIOR ACCESSES TO THEIR WORK AREAS.
- 6) CONDUCT PERIODIC DEPARTMENTAL INSERVICE TRAINING PROGRAMS ON BOMB THREAT AND SEARCH PROCEDURES.

### **HOSTILE PATIENTS, VISITORS, EMPLOYEES, OR INTRUDER**

ANY THREAT, VERBAL OR PHYSICAL, SHALL BE CONSIDERED REAL. ALL FACILITY STAFF MEMBERS SHOULD REMAIN CALM AND WILL COOPERATE WITH THE HOSTILE PERSON AND OFFER NO CHALLENGES. IF A PATIENT, VISITOR, OR EMPLOYEE BECOMES AGITATED OR HOSTILE, THE STAFF WILL DO THEIR BEST TO CALM THE PATIENT VERBALLY. THIS CAN USUALLY BE ACCOMPLISHED WITH A QUIET MANNER, REASSURANCE, AND/OR NEGOTIATION. IF THE INITIAL STAFF ATTEMPT IS UNSUCCESSFUL, THE FOLLOWING STEPS SHOULD BE TAKEN:

- 1) DO NOT PUT YOURSELF IN A COMPROMISING POSITION, EITHER VERBALLY OR PHYSICALLY.

**TITLE: N-110 BOMB THREATS, WORKPLACE VIOLENCE**

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- 2) ENLIST THE HELP OF YOUR CO-WORKERS. OFTEN, A CHANGE OF PERSONALITY WILL DEFUSE THE SITUATION.
- 3) IF UNSUCCESSFUL, NOTIFY YOUR DEPARTMENT MANAGER IMMEDIATELY. CONTACT THE ADMINISTRATOR IF NECESSARY
- 4) DO NOT ARGUE WITH THE PERSON. REMAIN CALM AND TRY NOT TO AGITATE THE PERSON FURTHER.
- 5) NEVER ATTEMPT TO DEAL WITH A PHYSICALLY AGGRESSIVE PATIENT OR INTRUDER.
- 6) DON'T IGNORE THREATS.
- 7) CALL 911 IF THE THREAT ESCALATES, FOR UNTHREATENING AGITATED PERSONNEL CALL THE SPARKS POLICE DEPARTMENT NON-EMERGENCY DISPATCH AT **775-353-2231**.
- 8) IF THE PERSON IS ARMED, COMPLY WITH THEIR DEMANDS AS MUCH AS POSSIBLE. DO NOT PUT YOURSELF IN A DANGEROUS POSITION BY RESISTING. MATERIAL ITEMS CAN BE REPLACED.
- 9) WHEN THE POLICE OFFICERS ARRIVE, DIRECT THEM TO THE LOCATION OF THE SITUATION. DO NOT ATTEMPT TO ASSIST THEM IN THEIR DUTIES, BUT A VAILABLE TO GIVE THEM INFORMATION.
- 10) ASSIST YOUR DEPARTMENT MANAGER/THE ADMINISTRATOR TO COMPLETE ANY POLICE REPORTS, VARIANCE REPORTS, OR INSURANCE CLAIMS IF NECESSARY.

SECTION: N SAFETY

DATE: 11/97, 7/03, 11/10, 5/16  
REVIEWED: 3/12

**TITLE: N-120 SMOKING POLICY**

**POLICY:** TO MINIMIZE FIRE DANGER AND TO PROMOTE A HEALTHY LIFESTYLE AND ENVIRONMENT WILDCREEK SUREGERY CENTER HAS CREATED A SMOKE FREE CAMPUS. THIS POLICY APPLIES TO ALL EMPLOYEES, VISITORS, PHYSICIANS,

***WILDCREEK SURGERY CENTER***

**POLICIES AND PROCEDURES**

AND PATIENTS. SMOKERS WILL BE ASKED TO REFRAIN FROM SMOKING  
UNTIL THEY HAVE LEFT THE PREMISES.

SECTION: N SAFETY

DATE: 11/97  
REVIEWED: 7/14, 5/16

TITLE: **N-130 FIRE SAFETY RULES AND REGULATIONS**

POLICY: WILDCREEK SURGERY CENTER WILL ENSURE THE SAFETY OF THE PATIENTS, STAFF, AND VISITORS THROUGH THE ENFORCEMENT OF FIRE SAFETY RULES AND REGULATIONS. THE LOCAL, STATE, AND FEDERAL LAWS AND ORDINANCES WILL BE INCLUDED IN THESE RULES.

A)     **FIRE REGULATIONS:**

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- 1) SMOKING IS PROHIBITED AT WILDCREEK SURGERY CENTER.
- 2) NO OPEN FLAMES ARE PERMITTED IN OR AROUND COMBUSTIBLE GASES OR ROOMS CONTAINING SUCH.
- 3) WHEN THE FIRE ALARM SOUNDS, ALL EMPLOYEES ARE TO RETURN TO THEIR ASSIGNED AREAS IMMEDIATELY.

### **B) FIRE ALARM PROCEDURE:**

- 1) THE PERSON DISCOVERING THE FIRE IS RESPONSIBLE FOR ACTIVATING THE FIRE ALARM SIGNAL BY PULLING DOWN ON THE FIRE ALARM HANDLE. THESE ALARMS ARE CLEARLY MARKED AND LOCATED THROUGHOUT THE CENTER. THE ALARM HANDLE IS LOCATED IN THE FRONT ENTRY VESTIBULE.
- 2) THE PERSON DISCOVERING THE FIRE WILL THEN REMOVE ALL PERSONS FROM THE IMMEDIATE DANGER AREA OF THE FIRE AND WILL CLOSE THE FIRE DOORS TO THE AREA.
- 3) THE PERSON DISCOVERING THE FIRE WILL THEN NOTIFY THE FRONT DESK RECEPTIONIST OF THE CENTER OF THE LOCATION, TYPE, AND SIZE OF THE FIRE. THIS IS ACCOMPLISHED BY DIALING "0" ON THE NEAREST PHONE.
- 4) WHEN THE FIRE ALARM SOUNDS, EMPLOYEES IN THEIR DESIGNATED AREAS WILL PROCEED WITH THE FOLLOWING:
  - A) REMOVE ALL PATIENTS, VISITORS, AND OTHER STAFF MEMBERS FROM IMMEDIATE DANGER.
  - B) CONTAIN THE FIRE BY CLOSING ALL FIRE DOORS IN THE AREA.
  - C) IF POSSIBLE, USE THE FIRE EXTINGUISHER TO FIGHT THE FIRE **ONLY** IF IT IS A SMALL FIRE THAT DOES NOT INVOLVE TOXIC CHEMICALS MATERIALS. IF THERE IS ANY DOUBT AS TO YOUR ABILITY TO EXTINGUISH THE FIRE, EVACUATE THE AREA.
- 5) THE FIRE ALARM SYSTEM IS CONNECTED TO THE ADT ALERT. THE CENTER'S RECEPTIONIST WILL ASSURE DOUBLING COVERAGE BY DIALING 911 AND REPORTING THE FIRE.

### **C) DESIGNATED AREA PROCEDURE:**

#### **1) BUSINESS OFFICE PERSONNEL:**

- A) CALL 911 AND REPORT THE FIRE SIZE, TYPE, AND LOCATION.
- B) DIRECT FIREMEN UPON ARRIVAL.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

C) RESPONSIBLE FOR EVACUATION OF PATIENTS AND VISITORS FROM THE FRONT WAITING AREA WHEN INDICATED.

### **2) PRE-OP/ADMITTING PERSONNEL:**

A) HAVE THE PARENTS OF PEDIATRIC VISITORS WALK WITH OR CARRY THEIR CHILDREN OUT THE NEAREST **SAFE** EXIT WHEN INDICATED.

B) USE WHEELCHAIRS OR STRETCHERS FOR UNSTEADY OR IMPAIRED PATIENTS.

C) REMAIN WITH THE PATIENTS AT A SAFE DISTANCE FROM THE BUILDING, AWAY FROM THE ENTRANCES WHEN EVACUATION IS INDICATED.

### **3) OPERATING ROOM PERSONNEL:**

A) TURN OFF THE GAS VALVES OF ALL GAS TANKS NOT IN USE.

B) IF SURGERY IS IN PROGRESS, ASSIST THE PHYSICIANS TO SECURE THE SURGERY SITE. OBTAIN, EQUIPMENT AND SUPPLIES FOR TRANSPORT IF THERE IS AN IMMEDIATE DANGER OF FIRE OR SMOKE ENTERING THE OPERATING ROOM.

C) IF THE FIRE IS IN ANOTHER PART OF THE BUILDING AND SAFELY SEPARATED FROM THE OPERATING AREA BY FIRE DOORS, CLOSE THE DOORS AND REMAIN WITH THE PHYSICIANS AND PATIENT.

D) IF MOVING OF THE PATIENT IS REQUIRED, ASSIST THE PHYSICIANS TO DO SO THROUGH THE NEAREST **SAFE** EXIT, OR TO ANOTHER SAFE PART OF THE BUILDING.

E) ENLIST ADDITIONAL HELP AS NEEDED FOR MOVING OF THE PATIENT AND ANESTHESIA MACHINE/EQUIPMENT.

F) IF YOUR ROOM WAS NOT IN USE AT THE TIME OF THE ALARM, REPORT TO THE NURSING MANAGER FOR DIRECTIONS ON WHERE ASSISTANCE IS NEEDED.

G) ASSIST AS NEEDED TO EVACUATE PATIENTS, VISITORS, AND OTHER STAFF MEMBERS.

H) EVACUATION OF ALL PATIENTS AND VISITORS SHOULD BE VIA THE FRONT ENTRANCE AND/OR THE WEST EMERGENCY EXIT IN THE SURGERY CENTER.

### **4) RECOVERY ROOM PERSONNEL:**

A) CLOSE ALL FIRE DOORS.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- B) USE PORTABLE OXYGEN TANKS ON PATIENTS THAT STILL REQUIRE OXYGEN ADMINISTRATION.
- C) TURN OFF ALL GAS VALVES LOCATED NEAR RECOVERY ROOM.
- D) IF THE FIRE IS LOCATED IN ANOTHER PART OF THE BUILDING AND IS SAFELY SEPARATED BY CLOSED FIRE DOORS, **AND** IF THERE IS NO SMOKE ENTERING THE PACU AREA, REMAIN WITH THE PATIENTS WHILE PREPARING AS MUCH AS POSSIBLE FOR EVACUATION.
- E) IF THERE IS SMOKE ENTERING THE PACU AREA, OR IF THE DANGER OF THE FIRE IS IMMEDIATE, EVACUATE PATIENTS THROUGH THE NEAREST **SAFE** EXIT. MOVE AWAY FROM THE BUILDING AND REMAIN WITH THE PATIENTS AT ALL TIMES.
- F) WHEN EVACUATING PATIENTS, USE STRETCHERS WHEN POSSIBLE. WHEELCHAIRS AND AMBULATION MAY ALSO BE USED AS EACH PATIENTS CONDITION PERMITS
- G) PRE-OPERATIVE PATIENTS WHO HAVE NOT RECEIVED SEDATION MAY BE AMBULATED OUT OF THE BUILDING IF THEIR CONDITION PERMITS.

### **5) ADMINISTRATOR/NURSE MANAGER**

- A) RESPOND TO AREA OF FIRE IMMEDIATELY AND DETERMINE IF EVACUATION OF AREA IS NECESSARY.
- B) ADVISE RECEPTIONIST OF PLAN OF ACTION SO THAT SHE/HE CAN NOTIFY APPROPRIATE PERSONNEL.
- C) ASSIST WITH CARE OF PATIENTS/STAFF IN IMMEDIATE DANGER.
- D) ASSURE THAT ALL PERSONS IN THE BUILDING HAVE SAFELY BEEN EVACUATED.
- E) ASSIST FIRE DEPARTMENT REPRESENTATIVE WITH ANY PERTINENT INFORMATION.
- F) ASSURE THAT STAFF IS RESPONSIVE TO PHYSICAL AND EMOTIONAL NEEDS OF PATIENTS AND VISITORS.
- G) CONDUCTS POST FIRE DE-BRIEFING OF STAFF, PERFORMS AN EVALUATION OF CAUSE OF FIRE AND RESPONSE OF STAFF AND EMERGENCY PERSONNEL.
- H) NOTIFICATION OF MANAGEMENT PERSONNEL, SAFETY AND RISK MANAGEMENT COMMITTEES AND OUTSIDE AGENCIES AS APPROPRIATE.

### **D) IMPORTANT POINTS FOR ALL STAFF MEMBERS:**

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **1) PREVENT FIRES:**

GOOD HOUSEKEEPING AND OBSERVING RULES ARE THE BEST DETERRENT FOR FIRES. MAKE IT A HABIT TO WATCH FOR FIRE HAZARDS AND REPORT ANY POSSIBLE DANGERS TO YOUR DEPARTMENT MANAGER.

### **2) KNOW THE LOCATION OF ALARMS, EXITS, AND EXTINGUISHERS:**

BE AWARE OF YOUR NEAREST ALARMS, EXITS, AND EXTINGUISHERS IN YOUR ASSIGNED WORK PLACE. REVIEW THE ESCAPE ROUTE WITH YOUR DEPARTMENT MANAGER IF YOU ARE UNSURE OF THE EXIT LOCATIONS. PARTICIPATE IN PRACTICES AND DRILLS AND KNOW HOW TO USE THE EQUIPMENT.

### **3) AVOID PANIC:**

THE GREATEST DANGER IN MOST FIRES IS **PANIC**. IF YOU REMAIN CALM, SO WILL YOUR CO-WORKERS. A QUIET, ASSURING MANNER WILL KEEP PATIENTS AND VISITORS CALM. THE PUBLIC WILL LOOK TO YOU FOR GUIDANCE AND WILL **PANIC** IF YOU DO. **NEVER** SHOUT "**FIRE**", AS THIS IS A SURE INVITATION FOR CHAOS.

### **4) KNOW YOUR ASSIGNED DUTIES IN A FIRE ALARM:**

DON'T SCOFF AT FIRE DRILLS OR REHEARSALS, PEOPLE'S LIVES ARE AT STAKE AND MAY DEPEND ON YOUR ACTIONS TO SAVE THEM. REVIEW THE FIRE PLAN FOR YOUR AREA AND LEARN HOW TO USE THE FIRE EXTINGUISHERS. ATTEND ALL IN-SERVICES AND ASK FOR YOUR DEPARTMENT MANAGER'S ASSISTANCE IF YOU ARE UNSURE OF ANY PART OF THE PLAN. **BE PREPARED!!**

### **5) BE ALERT FOR SIGNS OF FIRE:**

IF YOU SEE OR SMELL SMOKE INVESTIGATE AND REPORT IT AT ONCE. EVERY SECOND COUNTS IN A FIRE, AND THE FASTER IT IS CONTAINED, THE LESS DAMAGE AND LOSS IT IS LIKELY TO CAUSE.

### **6) FIRE DRILLS WILL BE CONDUCTED QUARTERLY:**

PER NEVADA STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES FIRE DRILLS WILL BE CONDUCTED AND DOCUMENTED ON A QUARTERLY BASIS.

**WILDCREEK SURGERY CENTER**

POLICIES AND PROCEDURES

SECTION: N SAFETY

DATE: 11/97, 7/03  
REVIEWED: 3/12, 5/16

TITLE: N-140 SAFETY RULES AND REGULATIONS (GENERAL)

POLICY:  
IT IS THE POLICY OF WILDCREEK SURGERY CENTER TO PROVIDE A SAFE, HEALTHFUL, AND SANITARY WORKING ENVIRONMENT FOR PATIENTS, STAFF, AND VISITORS. STANDARDS SHALL BE SET AND MAINTAINED ACCORDING TO LOCAL, STATE AND FEDERAL RULES, LAWS, AND REGULATIONS. IT IS ONE OF THE OBJECTIVES OF THE CENTER TO COMPLY WITH ALL RULES, MANDATES, LAWS, AND REGULATIONS PERTAINING TO THE SAFETY AND HEALTH OF ITS EMPLOYEES.

PROCEDURE:



# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

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.

PAGE 1 OF 3

SECTION: N SAFETY

DATE: 11/97, 7/03  
REVIEWED: 3/12, 5/16

TITLE: **N-140 SAFETY RULES AND REGULATIONS (GENERAL)**

- 5) OBSERVE THE BASIC RULES FOR LIFTING PATIENTS. PROPER BODY MECHANICS SHOULD BE USED WHEN LIFTING OR MOVING PATIENTS. REQUEST ASSISTANCE AS NECESSARY.
- 6) USE CARE WHEN APPROACHING SWINGING DOORS, CONGESTED AREAS, OR TURNING CORNERS. "NEVER RUN".
- 7) REPORT UNAUTHORIZED INDIVIDUALS NEAR OR IN THE FACILITY
- 8) DO NOT OPERATE EQUIPMENT UNLESS YOU HAVE BEEN PROPERLY INSTRUCTED.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- 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 FRA YED CORDS, OR IS MALFUNCTIONING IN ANY WAY.

PAGE 2 OF 3

SECTION: N SAFETY

DATE: 11/97, 7/03  
REVIEWED: 3/12, 5/16

TITLE: **N-140 SAFETY RULES AND REGULATIONS (GENERAL)**

18) MALFUNCTIONING OR BROKEN EQUIPMENT SHOULD BE IMMEDIATELY REMOVED FROM USE, APPROPRIATELY LABELED, REPORTED TO THE SUPERVISOR AND SUBMITTED FOR REPAIR WITH A LOCK-OUT TAG.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

PAGE 3 OF 3

SECTION: N SAFETY

DATE: 11/97, 7/03  
REVIEWED: 3/12, 5/16

**TITLE: N-150 SAFETY FOR OFFICE AREAS**

WILDCREEK SURGERY CENTER WILL ENSURE THAT THE CENTER IS MAINTAINED IN A SAFE AND ORDERLY MANNER.

PROCEDURE:

THE INDIVIDUALS WORKING IN THE OFFICE AREAS OF THE CENTER WILL MAINTAIN AN ENVIRONMENT FREE OF SAFETY HAZARDS. THESE PERSONS WILL BE COGNIZANT OF SAFETY ISSUES THAT ARE PRESENTED ON A DAY TO DAY BASIS WITHIN THEIR WORKING AREAS. ALL OFFICE WORKERS WILL BE RESPONSIBLE FOR THE FOLLOWING:

- 1) DESK AND COUNTER TOPS SHOULD BE FREE OF SHARP CORNERS.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- 2) MATERIALS SHOULD BE EVENLY DISTRIBUTED IN FILE CABINETS SO THAT THE UPPER DRAWERS DO NOT UNBALANCE THE FILE AND CAUSE THE FILE TO FALL OVER.
- 3) ONLY ONE FILE DRAWER SHOULD BE OPEN AT A TIME, AND EACH DRAWER WILL BE CLOSED AFTER USE.
- 4) PAPERS AND OTHER MATERIALS SHOULD BE KEPT OFF THE FLOORS AND OUT OF PATHWAYS.
- 5) ALL ELECTRICAL EQUIPMENT WILL BE PROPERLY GROUNDED.
- 6) HEAVY MATERIALS WILL BE STORED CLOSE TO THE GROUND, NEVER ON HIGH SHELVES OR ABOVE PATHWAYS.
- 7) ANY DEFICIENCIES OF THE ABOVE WILL BE REPORTED IMMEDIATELY TO THE APPROPRIATE DEPARTMENT MANAGER.
- 8) IN THE EVENT OF A FACILITY EMERGENCY, SUCH AS FIRE, IT WILL BE THE RESPONSIBILITY OF THE BUSINESS OFFICE MANAGER TO TRANSFER ALL PATIENT MEDICAL RECORDS TO A DESIGNATED AREA FOR SAFE KEEPING. IN THE ABSENCE OF THE BUSINESS OFFICE MANAGER, THE MEDICAL RECORDS COORDINATOR WILL ASSUME THIS RESPONSIBILITY.

SECTION: N SAFETY

DATE: 11/97, 7/03  
REVIEWED: 3/12, 5/16

### **TITLE: N-160 SAFE MEDICAL DEVICES ACT (SMDA)**

WILDCREEK SURGERY CENTER WILL SUPPORT AND COMPLY WITH THE SAFE MEDICAL DEVICES ACT (SMDA) WHICH BECAME EFFECTIVE ON NOVEMBER 28, 1991. THIS ACT REQUIRES THAT HEALTHCARE FACILITIES UTILIZING MEDICAL DEVICES WHICH HAVE CAUSED PATIENT CERTAIN ADVERSE OUTCOMES, TO REPORT SUCH EVENTS TO THE FDA AND/OR MANUFACTURER

### **PROCEDURE:**

- 1) A MEDICAL DEVICE IS DEFINED AS AN INSTRUMENT, IMPLEMENT, MACHINE, APPARATUS, IMPLANT, OR OTHER SIMILAR OR RELATED ARTICLE

**WILDCREEK SURGERY CENTER**

**POLICIES AND PROCEDURES**

INTENDED FOR USE IN DIAGNOSIS, CURE, TREATMENT, OR PREVENTION OF DISEASE.  
(PHARMACEUTICALS ARE NOT INCLUDED). EXAMPLES:  
ANESTHESIA MACHINES, DEFIBRILLATORS, CATHETERS, INTRAOCULAR  
LENSES, BLOOD GLUCOSE MONITORS, BREAST IMPLANTS, X-RAY  
MACHINES, AND LASERS TO NAME A FEW.

- 2) A REPORT WILL BE FILED WHEN INFORMATION EXISTS THAT REASONABLY SUGGESTS THERE IS A PROBABILITY THAT A DEVICE HAS CAUSED OR CONTRIBUTED TO THE DEATH, SERIOUS INJURY, OR SERIOUS ILLNESS OF A PATIENT.
- 3) THE REPORT WILL BE MADE WITHIN 10 WORKING DAYS AFTER BECOMING AWARE OF A REPORTABLE EVENT.
- 4) A SEMI-ANNUAL SUMMARY WILL BE MADE EVERY JANUARY AND JULY IF THE CENTER HAS EXPERIENCED A REPORTABLE EVENT.
- 5) THE REPORT WILL BE MADE TO THE FDA IN THE CASE OF A DEATH. THE REPORT WILL BE MADE TO THE MANUFACTURER IN THE CASE OF SERIOUS INJURY ILLNESS. IF THE MANUFACTURER IS UNKNOWN, THEN THE REPORT WILL BE TO THE FDA.
- 6) SEMI-ANNUAL REPORTS WILL BE MADE TO THE FDA:  
  
FOOD AND DRUG ADMINISTRATION  
CENTER FOR DEVICES AND RADIOLOGICAL HEALTH  
FDA USER REPORT  
P.O. BOX 3002  
ROCKVILLE, MD. 20847-3002

SECTION: N SAFETY

DATE: 11/97, 7/03  
REVIEWED: 3/12, 5/16

TITLE: N-160 SAFE MEDICAL DEVICES ACT (SMDA)

REPORT TO INCLUDE:  
FACILITY NAME AND ADDRESS  
PRODUCT, SERIAL NUMBER, MODEL NUMBER  
MANUFACTURER AND ADDRESS  
BRIEF DESCRIPTION OF EVENT

- 7) FDA REPORTING FORM WILL BE KEPT IN THE QA/RM OFFICE.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- 8) THE RISK MANAGEMENT NURSE, NURSE MANAGER, ADMINISTRATOR, AND MEDICAL DIRECTOR WILL WORK TOGETHER TO PROPERLY COMPLETE THE REPORTING FORM.
- 9) ANY DEVICE REPORTABLE WILL BE REMOVED FROM THE PATIENT CARE AREA AND LABELED "DEFECTIVE". THE DEVICE WILL NOT BE USED AGAIN UNTIL SERVICING HAS BEEN COMPLETED. THE DEVICE WILL BE EVALUATED BY AN INDEPENDENT BIOMEDICAL CONSULTANT BEFORE REPAIR AND WRITTEN EVALUATION SUBMITTED TO THE CENTER. THIS EVALUATION WILL BE ATTACHED TO THE FDA REPORTING FORM AND TO THE VARIANCE REPORT.

SECTION: N SAFETY

DATE: 7/03  
REVIEWED: 3/12, 5/16

**TITLE: N-170 EXTENSION CORD USE**

**POLICY:**

WILDCREEK SURGERY CENTER WILL COMPLY WITH FIRE AND SAFETY REGULATIONS TO ENSURE A SAFE WORKING ENVIRONMENT.

**PROCEDURE:**

1. EXTENSION CORD USE WILL BE LIMITED TO ONLY NECESSARY SITUATIONS.
2. ONLY GROUNDED (THREE PRONG) EXTENSION CORDS WILL BE UTILIZED.

***WILDCREEK SURGERY CENTER***

**POLICIES AND PROCEDURES**

- 3. EXTENSION CORDS WILL BE RATED WITH AS GREAT OR GREAT ELECTRICAL CAPACITY AS THE UNIT IT IS BEING CONNECTED WITH.
- 4. CARE WILL BE TAKEN THAT THE EXTENSION CORD IS NOT EXPOSED TO SPILL OR POOLING OF FLUIDS.

SECTION: N SAFETY

DATE: 11/97, 12/10, 8/12  
REVIEWED: 3/12, 5/16

**TITLE: N-180 EYE WASH STATIONS**

POLICY: WILDCREEK SURGERY CENTER WILL PROVIDE AND MAINTAIN A MEANS TO FLUSH THE EYES IN A SITUATION WHERE THE EYES HAVE BEEN SUBJECTED TO GASSES, SOLUTIONS, OR DEBRIS CAPABLE OF PRODUCING INJURY.

PROCEDURE:

- 1) EYE WASH STATIONS WILL BE ESTABLISHED AND MAINTAINED IN THE CENTER (CURRENTLY ONE STATION IS ESTABLISHED).

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- 2) SIGNS WILL BE POSTED DESIGNATING THE EYE WASH STATION.
- 3) OPERATION OF EYEWASH STATION:
  - TURN WATER FAUCET ON
  - PUSH BUTTON ON FAUCET OUTWARD
  - LEAN OVER SINK AND ALLOW STREAM OF WATER TO FLUSH EYES
  - 15 MINUTE FLUSH IS RECOMMENDED
- 4) MAINTENANCE
  - THE STATION WILL BE CHECK DAILY AND DOCUMENTED ON THE CRASH CRASHCART CHECK LIST
  - PLASTIC PROTECTIVE COVERS WILL BE REPLACED WHEN LOST OR DAMAGED.

SECTION: N SAFETY

DATE: 11/97, 7/03, 3/11, 12/16  
REVIEWED: 3/12, 5/16

**TITLE: N-190 HAZARDS, RECALLS AND ALERTS**

POLICY: THE NURSING MANAGER OF WILDCREEK SURGERY CENTER WILL BE RESPONSIBLE FOR ALL HAZARDS, RECALLS, AND ALERTS. THIS PERSON WILL COLLECT AND REVIEW ALL DATA CONCERNING DEFECTIVE EQUIPMENT, SUPPLIES, MEDICATIONS AND FOOD PRODUCTS WHICH MAY AFFECT THE GENERAL SAFETY OR PRESENT A RISK TO PATIENT CARE, VISITORS, OR CENTER STAFF.



# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

PROCEDURE: THE NURSE MANAGER WILL:

- REVIEW ALL DATA COLLECTED FROM ALL SOURCES CONCERNING RECALLS OR ALERTS OF DEFECTIVE OR HAZARDOUS EQUIPMENT, SUPPLIES, MEDICATIONS AND FOOD PRODUCTS.
- TAKE IMMEDIATE ACTION AS NECESSARY TO PROVIDE THE PROPER PROTECTION OF ALL PATIENTS, VISITORS, AND STAFF MEMBERS. REMOVE RECALLED EQUIPMENT, SUPPLIES, MEDICATION, OR FOOD PRODUCT FROM PATIENT USE AREA IMMEDIATELY.
- FOLLOW MANUFACTURER OR DISTRIBUTORS INSTRUCTION AS TO DISPOSITION OF RECALLED PRODUCT.
- INFORM THE CENTER'S ADMINISTRATOR AND MEDICAL DIRECTOR.
- DISSEMINATE HAZARDOUS RECALL OR ALERT INFORMATION TO APPROPRIATE STAFF MEMBERS INVOLVED IN THE UTILIZATION OF THE POTENTIAL HAZARDOUS EQUIPMENT, SUPPLIES, MEDICATIONS AND FOOD PRODUCTS.
- COLLECT, COORDINATE, AND EVALUATE INFORMATION RETURNED FROM THE INVOLVED AREAS TO ASSURE THAT ANY ACTION REQUIRED HAS BEEN ADDRESSED AND HANDLED TO MINIMIZE RISK ASSOCIATED WITH THE ITEM IN QUESTION.
- MONITOR ALL OUTSTANDING RECALLS TO ASSURE THAT ALL ISSUES OR POTENTIAL PRODUCT LIABILITIES HAVE BEEN RESOLVED TO COMPLETION.
- MAINTAIN SUPPORTING DOCUMENTATION WITHIN THE CENTER.
- REPORT RESULTS INCLUDING ANY ACTIONS TAKEN TO THE QAPI COMMITTEE.
- CALL IN OTHER PERSONNEL AS NEEDED TO ASSIST IN FINDING RESOLUTIONS TO IDENTIFIED ISSUES AS NECESSARY THIS PERSON WILL COLLECT AND REVIEW CONCERNING DEFECTIVE EQUIPMENT SUPPLIES, MEDICATIONS AND FOOD PRODUCTS WHICH MAY EFFECT PATIENTS, VISITORS, OR CENTER STAFF.

SECTION: N SAFETY

DATE: 11/97, 7/03, 8/12  
REVIEWED: 3/12, 5/16

TITLE: **N-200 MEDICAL WASTE MANAGEMENT**

POLICY:

WILDCREEK SURGERY CENTER WILL COMPLY WITH ALL LOCAL, STATE, AND FEDERAL LAWS, RULES, AND REGULATIONS GOVERNING THE HANDLING AND DISPOSAL OF CONTAMINATED MEDICAL WASTE. THE CENTER WILL PROTECT ALL EMPLOYEES, VISITORS, AND STAFF MEMBERS FROM POSSIBLE EXPOSURE TO INFECTIOUS DISEASES THROUGH A WASTE MANAGEMENT PROGRAM. IN ADDITION, THE CENTER WILL PROTECT THE PUBLIC AND THE ENVIRONMENT IN GENERAL BY CONTAINING ALL CONTAMINATED WASTES PRIOR TO THEIR DISPOSAL SO AS NOT TO CAUSE INFECTIOUS DISEASE TO BE SPREAD. THESE CONTAMINATED WASTES WILL BE CONTAINED AND DISPOSED OF IN A SAFE AND APPROVED MANNER.

**WILDCREEK SURGERY CENTER**

**POLICIES AND PROCEDURES**

**PROCEDURE:**

DEFINITION-INFECTIOUS MEDICAL WASTE:  
BIOHAZARDOUS WASTE IS ANY SOLID OR LIQUID WASTE WHICH MAY PRESENT A  
THREAT OF INFECTION TO HUMANS. THE REQUIREMENTS FOR INDUCTION  
OF DISEASE IS THE PRESENCE OF A PATHOGEN WITH SUFFICIENT VIRULENCE  
AND IN A QUANTITY SUBSTANTIAL ENOUGH SO THAT EXPOSURE TO THE  
WASTE BY A SUSCEPTIBLE HOST OR ORGANISM COULD RESULT IN AN INFECTIOUS DISEASE.

IDENTIFICATION OF MEDICAL WASTE:  
ISOLATION WASTE FROM PATIENTS WITH INFECTIOUS DISEASE CULTURES AND  
STOCKS OF INFECTIOUS AGENTS AND ASSOCIATED BIOLOGICALS HUMAN BLOOD  
AND BLOOD PRODUCTS; USED, ABSORBENT MATERIALS SUCH AS BANDAGES,  
SPONGES, AND GAUZE SUPERSATURATED WITH BLOOD OR BODY FLUIDS HAVING  
THE POTENTIAL TO DRIP OR SPLASH  
  
PATHOLOGICAL WASTE; TISSUES, ORGANS, OR BODY PARTS  
  
CONTAMINATED SHARPS; HYPODERMIC NEEDLES, SYRINGES, PIPETTES, BROKEN  
GLASS, SCALPEL BLADES, SUTURING NEEDLES, TROCARS, ETC.

- 1) THE NURSE MANAGER WILL BE RESPONSIBLE FOR THE DEVELOPMENT  
AND MAINTENANCE OF A MEDICAL WASTE MANAGEMENT PROGRAM.
- 2) THE WASTE MANAGEMENT PROGRAM WILL INCLUDE:
  - A) EMPLOYEE TRAINING IN MEDICAL WASTE HANDLING
  - B) MONITORING OF PROPER PACKAGING AND LABELING
  - C) FOLLOW-THROUGH ON TRACKING PROCEDURES
  - D) CONTINGENCY/EMERGENCY PLAN

PAGE 1 OF 3

SECTION: N SAFETY

DATE: 11/97, 7/03, 8/12  
REVIEWED: 3/12, 3/15, 5/16

TITLE: N-200 MEDICAL WASTE MANAGEMENT

- 3) ALL POTENTIALLY INFECTIOUS MEDICAL WASTE WILL BE SEPARATED FROM  
GENERAL FACILITY GARBAGE AT ITS POINT OF ORIGIN.
- 4) ALL POTENTIALLY INFECTIOUS MEDICAL WASTE WILL BE PLACED IN BOXES  
LABELED "BIOHAZARD WASTE" THAT CONSPICUOUSLY DISPLAYED THE  
BIOHAZARD SYMBOL. THESE BOXES WILL BE LINED WITH TWO (2) RED PLASTIC

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

BAGS THAT ARE IMPERVIOUS TEAR RESISTANT, AND WITH SEAMS THAT ARE OF EQUAL RESISTANCE TO TEARING AND LEAKING.

- AND  
BOX,
- 5) EACH HAZARDOUS WASTE BOX WILL NOT EXCEED A FIFTY (50) POUND MAXIMUM WEIGHT LIMIT.
  - 6) ALL FLUIDS PLACED IN THE HAZARDOUS WASTE BOX WILL BE CONTAINED; CAPS WILL BE PLACED SECURELY ON ALL PORTS OF SUCTION CONTAINERS. BULK BLOOD, SUCTIONED FLUIDS EXCRETIONS, AND SECRETIONS MAY BE CAREFULLY POURED DOWN A DRAIN CONNECTED TO SANITARY SEWER.
  - 7) NEEDLES WILL NOT BE BENT BROKEN OR RECAPPED AND WILL BE PLACED IN APPROVED SHARPS CONTAINERS IMMEDIATELY AFTER USE. ALL SHARPS WILL FIRST BE PLACED IN A PUNCTURE PROOF SHARPS CONTAINER. WHEN **TWO THIRDS**, THE SHARPS CONTAINER WILL BE SECURELY CLOSED AND LOCED IN THE BIOHAZARD CABINET UNTIL PICK-UP
  - 8) FILLED HAZARDOUS WASTE BOXES WILL BE SECURED BY FOLDING THE INNER RED BAG OVER THE CONTENTS, THEN TWISTING THE OUTER RED BAG CLOSED SECURELY WITH A TIE. THE LID MUST BE ABLE TO FIT SNUGLY ON TO THE BOXES WILL NOT BE OVERFILLED.
  - 9) SECURED HAZARDOUS WASTE BOXES WILL BE LOCKED IN THE BIO-HAZARD CABINET UNTIL PICK-UP. THIS AREA HAS BEEN DESIGNATED FOR CONTAMINATED WASTE CONTAINERS AND HAS RESTRICTED ACCESS BY UNAUTHORIZED PERSONS.
  - 10) PICK-UP WILL BE ARRANGED ON AN AS NEEDED BASIS.

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SECTION: N SAFETY

DATE: 11/97, 7/03, 8/12

REVIEWED: 3/12, 5/16

TITLE: **N-200 MEDICAL WASTE MANAGEMENT**

- 11) IN THE EVENT OF LEAKAGE OR ACCIDENTAL SPILL OF A HAZARDOUS WASTE BOX, PROTECTIVE ATTIRE WILL BE WORN, AND THE CONTENTS WILL BE PLACED IN AN INTACT BIO-HAZARDOUS WASTE BOX. SPILLS WILL BE CLEANED UP USING A GERMICIDAL AGENT AND DISPOSABLE TOWELS. ALL MATERIALS USED IN CLEANING THE SPILL WILL THEN BE DISPOSED OF IN A HAZARDOUS WASTE BOX; SATURATED OR DRIPPING MATERIALS WILL FIRST PLACED IN A PLASTIC BAG.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- 12) TRANSPORTATION OF THE FILLED HAZARDOUS WASTE BOXES OFF THE PREMISES WILL BE BY ENCLOSED, LEAK PROOF TRUCKS.
- 13) DOCUMENTATION OF PICK-UP WILL BE MAINTAINED BY THE CENTER; DOCUMENTATION OF APPROPRIATE DISPOSAL WILL BE MAINTAINED BY THE RECEIVING SERVICE AS WELL AS TRACKING OF CENTER VOLUME.
- 14) WASTE MANAGEMENT IS A STATE APPROVED BIO-HAZARDOUS WASTE DISPOSAL SERVICE AND WILL BE UTILIZED FOR THE COLLECTION OF WILDCREEK SURGERY CENTER BIO-HAZARDOUS WASTE.
- 15) POLICIES AND PROCEDURES RELATING TO THE OPERATION OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT SYSTEM WILL BE REVIEWED ANNUALLY.
- 16) THE QUALITY IMPROVEMENT/RISK MANAGEMENT COMMITTEE WILL BE RESPONSIBLE FOR TRACKING THE MANAGEMENT OF BIO-HAZARDOUS WASTE, SECURING REGULATIONS, AND MAINTAINING COMMUNICATION FOR OPERATION OF SERVICE WITH B & L DISPOSAL.

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SECTION: N SAFETY

DATE: 11/97, 7/03  
REVIEWED: 3/12, 5/16  
REVISED: 7/19

**TITLE: N-210 HAZARDOUS MATERIALS COMMUNICATION PROGRAM**

**POLICY:** WILDCREEK SURGERY CENTER WILL MAINTAIN AN UP TO DATE PROGRAM FOR THE PURPOSE OF COMMUNICATING TO EMPLOYEES ON HAZARDOUS CHEMICALS IN THE WORK PLACE.

**PROCEDURE:**

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

### **RECORD KEEPING:**

- 1)     **SAFETY DATA SHEETS:**  
THESE WILL BE KEPT UP TO DATE WITH ALL CURRENT AND ANY NEW  
CHEMICALS IN THE CENTER.
- 2)     **EMPLOYEE SIGN OFF SHEETS:**  
WHEN EMPLOYEES ATTEND THE HAZARDOUS COMMUNICATIONS  
PROGRAM AS PART OF THEIR ORIENTATION, THEY WILL SIGN AND  
DATE A FORM ACKNOWLEDGING THIS. THESE COMPLETED FORMS  
WILL BE KEPT IN PERSONNEL FILES.
- 3)     **RESPONSIBILITIES:**  
THE CENTER'S NURSING MANAGER WILL BE RESPONSIBLE FOR  
ASSURING THAT ALL EMPLOYEES RECEIVE THE HAZARDOUS  
MATERIAL INFORMATION.

SECTION; N SAFETY

DATE: 11/97, 7/03, 9/09  
REVIEWED: 3/12, 5/16,  
REVISED: 7/19

**TITLE: N-220 HAZARDOUS MATERIALS EDUCATION, ORIENTATION, AND TRAINING**

**POLICY: WILDCREEK SURGERY CENTER WILL PROVIDE THE EMPLOYEES WITH INFORMATION  
AND TRAINING ON HAZARDOUS MATERIALS IN THE WORK AREA AT THE TIME OF  
EMPLOYMENT AND WHEN NEW HAZARDOUS MATERIALS ARE INTRODUCED INTO  
HIS/HER WORK AREAS.**

**WILDCREEK SURGERY CENTER**

**POLICIES AND PROCEDURES**

ACTION: THE EMPLOYEE WILL BE ABLE TO IDENTIFY AND VERBALIZE:

- 1. THE LOCATION AND STORAGE OF POTENTIALLY HAZARDOUS MATERIALS IN THE WORK AREA.
- 2. THE PHYSICAL AND HEALTH HAZARDS OF MATERIALS IN THE WORK AREA.
- 3. THE LABELING INFORMATION REQUIRED ON ALL POTENTIALLY HAZARDOUS MATERIALS.
- 4. THE MEASURES TO BE TAKEN TO PROTECT HIM/HER FROM EXPOSURE TO HAZARDOUS MATERIALS, SUCH AS APPROPRIATE WORK PRACTICES, EMERGENCY PROCEDURES AND THE PERSONAL PROTECTIVE EQUIPMENT TO BE USED.
- 5. LOCATION OF SAFETY AIDS SUCH AS SHOWERS, EYE WASH STATIONS, FIRE EXTINGUISHERS, ETC.
- 6. LOCATION AND CONTENT OF THE SAFETY DATA SHEET (SDS).
- 7. THE REQUIREMENT OF COMPLETION OF THE HAZARDOUS COMMUNICATION PROGRAM AT THE TIME OF EMPLOYMENT AND ANNUALLY.

|            |              |
|------------|--------------|
| DATE _____ | SIGNED _____ |
| DATE _____ | SIGNED _____ |
| DATE _____ | SIGNED _____ |
| DATE _____ | SIGNED _____ |
| DATE _____ | SIGNED _____ |
| DATE _____ | SIGNED _____ |

SECTION: N SAFETY

DATE: 11/97, 7/03, 5/16  
REVIEWED: 3/12  
REVISED: 7/19

TITLE: **N-230 HAZARDOUS MATERIALS SPILL    OR ACCIDENT**

POLICY: WILDCREEK SURGERY CENTER WILL PROTECT ALL PATIENTS, VISITORS, AND STAFF MEMBERS FROM THE POTENTIAL DANGERS OF A HAZARDOUS MATERIAL SPILL BY FOLLOWING THE PROCEDURE LISTED BELOW.

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

- PROCEDURE:
- 1) REGULAR INSPECTIONS WILL BE MADE OF THE STORAGE SITES FOR ALL HAZARDOUS MATERIALS. THESE INSPECTIONS WILL BE MADE FOR THE PURPOSE OF DETECTING ANY LEAKING OR SPILLED CONTAINERS. IF ANY LEAKS OR SPILLS ARE FOUND, THE FOLLOWING STEPS WILL BE TAKEN:
  - 2) BEFORE ATTEMPTING TO CLEAN UP ANY HAZARDOUS CHEMICAL SPILL, KNOW WHAT THE CHEMICAL IS!
  - 3) OBTAIN THE SAFETY DATA SHEET (SDS) FOR THAT PARTICULAR PRODUCT. THE SAFETY DATA SHEETS ARE KEPT CLEARLY MARKED BINDERS IN THE ANESTHESIA WORK ROOM.
  - 4) FOLLOW THE DIRECTIONS ON THE SDS FOR THAT PRODUCT TO ACQUIRE THE PROPER PROTECTIVE CLOTHING/EQUIPMENT AND TO CLEAN UP THE LEAK OR SPILL.
  - 5) ENSURE ADEQUATE VENTILATION FOR THE TASK.
  - 6) IF NECESSARY, EVACUATE ALL PERSONS FROM THE AREA BEFORE DOING THE CLEAN UP.
  - 7) IF A FIRE OCCURS, PROCEED WITH THE FIRE ALARM PROCEDURE (SEE "FIRE SAFETY RULES AND REGULATION").
  - 8) AVOID TRACKING THROUGH THE SPILL DURING THE CLEAN UP.
  - 9) COMPLETE A VARIANCE REPORT ON THE LEAK OR SPILL.
  - 10) NOTIFY THE NURSING MANAGER OF ALL LEAKS/SPILLS.

SECTION: N SAFETY

DATE: 11/97, 7/03  
REVIEWED: 3/12, 5/16  
REVISED: 7/19

TITLE: **N-240 HAZARDOUS MATERIALS**

### **POLICY:**

WILDCREEK SURGERY CENTER WILL COMPLY WITH ALL LOCAL, STATE, AND FEDERAL RULES AND REGULATIONS GOVERNING THE USE, HANDLING, AND STORAGE OF ALL HAZARDOUS MATERIALS. THE CENTER'S RISK MANAGEMENT COMMITTEE IS RESPONSIBLE FOR DEVELOPING AND

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

IMPLEMENTING A CENTER-WIDE HAZARDOUS MATERIAL SAFETY PROGRAM WHICH WILL INCLUDE:

- 1) IDENTIFICATION OF HAZARDOUS MATERIALS USED WITHIN THE CENTER.
- 2) MAINTAIN AND MONITOR APPROPRIATE SAFETY DATA SHEETS ON ALL MATERIAL THAT IS CONSIDERED HAZARDOUS.
- 3) TRAINING OF EMPLOYEES WHO HANDLE OR ARE EXPOSED TO THE HAZARDOUS MATERIALS WITH EMPHASIS ON SAFETY ASPECTS ASSOCIATED WITH THE HAZARDOUS MATERIALS.
- 4) IMPLEMENTATION AND ON-GOING MONITORING OF THE HAZARDOUS MATERIAL POLICY.

PROCEDURE: **EMPLOYEE INFORMATION AND TRAINING:**

THE CENTER'S DEPARTMENT MANAGERS WILL PROVIDE THEIR EMPLOYEES WITH INFORMATION AND TRAINING ON HAZARDOUS CHEMICALS IN THEIR WORK AREA AT THE TIME OF THEIR INITIAL ASSIGNMENT, AND WHENEVER A NEW HAZARD IS INTRODUCED INTO THEIR WORK AREA. INFORMATION AND TRAINING WILL CONSIST OF THE FOLLOWING:

- A) THE REQUIREMENTS OF THIS POLICY;
- B) ANY OPERATIONS IN THEIR WORK AREA WHERE HAZARDOUS MATERIALS ARE PRESENT;
- C) THE LOCATION AND AVAILABILITY OF WRITTEN HAZARD COMMUNICATIONS, INCLUDING THE REQUIRED LIST OF HAZARDOUS MATERIALS AND SAFETY DATA SHEETS REQUIRED BY THIS POLICY;
- D) METHODS AND OBSERVATIONS THAT MAY BE USED TO DETECT THE PRESENCE OR RELEASE OF A HAZARDOUS MATERIAL INTO THEIR WORK AREA;
- E) THE PHYSICAL AND HEALTH HAZARDS OF THE MATERIALS IN THE WORK AREA;

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SECTION: N SAFETY

DATE: 11/97, 7/03  
REVIEWED: 3/12, 5/16  
REVISED: 7/19

TITLE: **N-240 HAZARDOUS MATERIALS**

- F) THE MEASURES EMPLOYEES CAN TAKE TO PROTECT THEMSELVES FROM THESE HAZARDS, INCLUDING SPECIFIC PROCEDURES THE EMPLOYER HAS IMPLEMENTED TO PROTECT EMPLOYEES FROM EXPOSURE TO HAZARDOUS MATERIALS, SUCH AS



# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

APPROPRIATE WORK PRACTICES, EMERGENCY PROCEDURES, AND PERSONAL PROTECTIVE EQUIPMENT TO BE USED.

- G) THE DETAILS OF THE HAZARD COMMUNICATIONS PROGRAM DEVELOPED BY THE EMPLOYER, INCLUDING AN EXPLANATION OF THE LABELING SYSTEM AND THE SAFETY DATA SHEET, AND HOW EMPLOYEES CAN OBTAIN AND USE THE APPROPRIATE HAZARD INFORMATION;
- H) DOCUMENTATION IN EACH EMPLOYEE'S FILE THAT THE ABOVE MATERIAL HAS BEEN DISCUSSED AT LEAST ON AN ANNUAL BASIS.

### **2) DEFINITION AND RESPONSIBILITIES:**

- A) A HAZARDOUS MATERIAL IS DEFINED AS ANY CHEMICAL THAT IS TOXIC, FLAMMABLE, CORROSIVE, REACTIVE, OR CAPABLE OF CAUSING HARM OR SERIOUS INJURY TO HUMANS, ANIMALS, OR THE ENVIRONMENT.
- B) THE ADMINISTRATOR AND DEPARTMENT MANAGERS HAVE THE AUTHORITY TO INSTITUTE THE EMERGENCY PLAN IN THE EVENT OF A MAJOR CHEMICAL WASTE ACCIDENT OR SPILL OF A HAZARDOUS MATERIAL.
- C) A SAFETY DATA SHEET (SDS) IS REQUIRED AND COMPLETED BY ALL VENDORS. MSDS'S ARE MAINTAINED WITHIN EACH DEPARTMENT ON EVERY CHEMICAL USED WITHIN THEIR AREA.
- D) A MASTER FILE OF ALL THE SDS'S IS TO BE MAINTAINED BY THE RISK MANAGEMENT NURSE AND THE SPARKS FIRE DEPARTMENT FOR USE IN THE EVENT OF A HAZARDOUS CHEMICAL SPILL, SPLASH, BURN, OR OTHER ACCIDENTS.
- E) IT IS THE RESPONSIBILITY OF THE DEPARTMENT USING THE HAZARDOUS MATERIAL TO DETERMINE IF A LESS HAZARDOUS ONE MAY BE SUBSTITUTED.
- F) ALL PERSONS REQUIRED TO HANDLE THE HAZARDOUS CHEMICALS OR MATERIALS WILL BE PROVIDED WITH APPROPRIATE ORIENTATION, EQUIPMENT, AND ON THE JOB TRAINING.

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- G) EACH DEPARTMENT THAT GENERATES OR HANDLES CHEMICAL WASTE WILL HAVE WRITTEN, SPECIFIC POLICIES AND PROCEDURES THAT CONTAIN INFORMATION

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PERTINENT TO THAT DEPARTMENT. THESE POLICIES AND PROCEDURES WILL BE REVIEWED ANNUALLY AND APPROVED BY THE QA COMMITTEE.

### **HAZARDOUS MATERIALS RIGHT TO KNOW:**

OSHA MAINTAINS A REGULATION TO PROTECT EMPLOYEES FROM POSSIBLE ADVERSE EFFECTS OF POTENTIALLY HAZARDOUS CHEMICALS THEY MAY ENCOUNTER IN THE WORK PLACE. EMPLOYEES WILL BE PROVIDED WITH INFORMATION REGARDING:

- A) THE POTENTIALLY HAZARDOUS CHEMICALS THEY MAY COME INTO CONTACT WITH IN THEIR WORK AREA;
- B) THE NATURE OF THE POTENTIALLY HAZARDOUS CHEMICALS WITH WHICH THEY WORK;
- C) THE PERSONAL PROTECTIVE EQUIPMENT THAT SHOULD BE WORN IN DEALING WITH CHEMICALS;
- D) WHERE THEY CAN GO FOR ADDITIONAL INFORMATION ABOUT THE CHEMICALS THEY MAY ENCOUNTER;
- E) STORAGE OF POTENTIALLY HAZARDOUS CHEMICALS;
- F) LOCATION OF EXISTING SAFETY AIDS SUCH AS SHOWERS, EYE WASHES, ETC.

### **LABELING INFORMATION:**

THE FOLLOWING LABELING INFORMATION IS REQUIRED ON ALL POTENTIALLY HAZARDOUS MATERIALS:

- A) CHEMICAL NAME;
- B) CHEMICAL ABSTRACT NUMBER ("CAS"), A UNIQUE NUMBER ASSIGNED BY THE FEDERAL GOVERNMENT TO EACH CHEMICAL;
- C) APPROPRIATE HAZARD WARNINGS (FIRE, REACTIVITY, HEALTH);

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- D) TARGET ORGAN INFORMATION, SUCH AS THE SPECIFIC ORGAN OR ORGAN GROUPS THAT EXPOSURE TO THE CHEMICAL MAY EFFECT;

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- E) IN SOME CASES, THE PERSONAL PROTECTIVE EQUIPMENT TO BE USED IN HANDLING THE CHEMICAL IS STATED.

### **SAFETY DATA SHEETS:**

ALL SAFETY DATA SHEETS WILL CONTAIN THE FOLLOWING INFORMATION IF APPLICABLE:

- A) IDENTITY: WHO MAKES IT, THEIR ADDRESS, EMERGENCY TELEPHONE NUMBER, AND DATE PREPARED.
- B) HAZARDOUS INGREDIENTS: HAZARDOUS COMPONENTS, CHEMICAL ID, AND COMMON NAMES. WORKER EXPOSURE LIMITS SUCH THE OSHA PEL AND ACGIH TLV AND OTHER RECOMMENDED LIMITS ARE ALSO INCLUDED IN THIS SECTION.
- C) PHYSICAL/CHEMICAL CHARACTERISTICS: ITEMS SUCH AS BOILING POINT, VAPOR PRESSURE, VAPOR DENSITY, MELTING POINT, EVAPORATION RATE, WATER SOLUBILITY, APPEARANCE, AND ODOR UNDER NORMAL CONDITIONS.
- D) PHYSICAL HAZARDS: SUCH AS FIRE, EXPLOSION, WAYS TO HANDLE THOSE HAZARDS, APPROPRIATE FIRE FIGHTING EQUIPMENT, ETC.
- E) REACTIVITY: THIS TELLS YOU WHETHER THE SUBSTANCE IS STABLE. THIS TELLS YOU WHICH SUBSTANCE AND SITUATIONS TO KEEP IT AWAY FROM SO IT WON'T REACT.
- F) HEALTH HAZARDS: HOW THE CHEMICAL CAN ENTER THE BODY, ALL POSSIBLE HEALTH HAZARDS THAT COULD COME FROM EXPOSURE, SIGNS AND SYMPTOMS OF EXPOSURE, AND EXISTING MEDICAL CONDITIONS THAT COULD BE AGGRAVATED BY EXPOSURE. THIS AREA ALSO COVERS EMERGENCY AND FIRST AID PROCEDURES IF AN ACCIDENT DOES HAPPEN.
- G) PRECAUTIONS FOR SAFE HANDLING AND USE: THIS SECTION TELLS YOU WHAT TO DO IF A SUBSTANCE SPILLS OR LEAKS, HOW TO DISPOSE OF THE SUBSTANCE, EQUIPMENT AND PROCEDURES NEEDED FOR CLEANING UP SPILLS AND LEAKS, AND HOW TO HANDLE THE SUBSTANCE AND HOW TO STORE IT.

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- H) CONTROL MEASURES: THIS SECTION TELLS YOU HOW TO REDUCE HARMFUL EXPOSURE. IT DEALS WITH WHAT TYPE OF RESPIRATOR, GLOVES, EYE SHIELDS, PROTECTIVE CLOTHING, AND VENTILATION TO USE WHEN HANDLING THAT PARTICULAR CHEMICAL. ALSO, SPECIAL HYGIENE PRACTICES THAT SHOULD BE FOLLOWED WILL BE INCLUDED HERE.

IT MUST BE NOTED THAT NOT ALL INFORMATION WILL BE ON ALL SDS'S. SOME INFORMATION DOES NOT PERTAIN TO CERTAIN CHEMICALS. WHEN MANUFACTURERS OR SUPPLIERS USE A STANDARD FORMAT SHEET, THOSE AREAS WILL USUALLY SAY "N/A". IT IS REQUIRED, HOWEVER, THAT ALL PERTINENT INFORMATION BE DISCLOSED ON EACH CHEMICAL. THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) HAS ISSUED A HAZARD COMMUNICATION STANDARD THAT SAYS ALL EMPLOYEES HAVE A "RIGHT TO KNOW" WHAT HAZARDS THEY FACE ON THE JOB AND HOW TO PROTECT THEMSELVES AGAINST THOSE HAZARDS.

IN ADDITION, ALL HAZARDOUS CHEMICALS WILL BE IDENTIFIED USING THE CRITERIA DEFINED BY THE RESOURCE CONSERVATION AND RECOVERY ACT OF 1976 (RCRA), SUBTITLE C, HAZARDOUS WASTE REGULATIONS, 40CFR, PART 261. A BRIEF SUMMARY OF THIS IDENTIFICATION CRITERIA IS AS FOLLOWS:

1) CHEMICAL CHARACTERISTICS:

- AND A) IGNITABLE (FLAMMABLE). EXAMPLES: XYLENE, BENZENE, ETHYL ETHER, ACETONE, METHANOL.
- ACID, B) CORROSIVE (PH 2.0 OR PH 12.5). EXAMPLES: SODIUM HYDROXIDE, HYDROCHLORIC SULFURIC ACID.
- C) REACTIVITY (UNSTABLE AT NORMAL TEMPERATURES AND PRESSURES, OR MAY RELEASE EXPLOSIVE VAPORS).
- D) TOXICITY (TOXIC DUE TO CONTAMINATED HEAVY METALS OR SPECIFIC CHLORINATED ORGANICS).

2) ACUTELY HAZARDOUS CHEMICAL WASTES: EXAMPLES: ARSENATE AND ARSENIC CONTAINING COMPOUNDS, CYANIDE CONTAINING COMPOUNDS, WARFARIN, PARATHION, SODIUM AZIDE.

3) COMMERCIAL CHEMICAL PRODUCTS AND MANUFACTURING CHEMICAL INTERMEDIATES: EXAMPLES: CARBON TETRACHLORIDE, CHLORDANE, CHLOROFORM, PYRIDINE, TOLUENE.

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- 4) TOXIC WASTE: EXAMPLES: PHENOL, RESERPINE PCB'S.
- 3) STORAGE:
  - A) MATERIALS WHICH IGNITE EASILY UNDER NORMAL CONDITIONS (FLAMMABLES) ARE CONSIDERED FIRE HAZARDOUS AND WILL BE STORED IN A COOL, DRY, WELL VENTILATED STORAGE SPACE. THESE MATERIALS WILL BE KEPT WELL AWAY FROM SOURCES OF HEAT, FIRE, OR FLAME.
  - B) HIGHLY FLAMMABLE MATERIALS WILL BE KEPT IN AN AREA SEPARATE FROM OXIDIZING AGENTS (MATERIALS SUSCEPTIBLE TO SPONTANEOUS COMBUSTION OR HEATING, EXPLOSIVES, ETC).
  - C) THE STORAGE AREA FOR FLAMMABLES WILL BE SUPPLIED WITH FIRE FIGHTING EQUIPMENT, EITHER AUTOMATIC OR MANUAL. THERE WILL BE "NO SMOKING" SIGNS POSTED IN AND AROUND THE STORAGE AREA.
  - D) OXIDIZERS WILL NOT BE STORED CLOSE TO LIQUIDS OF LOW FLASH POINT.
  - E) ACIDS AND ACID FUME SENSITIVE MATERIALS WILL BE STORED IN A COOL, DRY, WELL VENTILATED AREA, PREFERABLY WOODEN.
  - F) MATERIALS WHICH ARE TOXIC AS STORED, OR CAN DECOMPOSE INTO TOXIC COMPONENTS WILL BE KEPT FROM CONTACT WITH HEAT, MOISTURE, ACIDS, OR ACID FUMES.
  - G) CORROSIVE MATERIALS WILL BE STORED IN A COOL, WELL VENTILATED AREA, BUT WILL BE KEPT ABOVE THE FREEZING POINT. THE CONTAINERS WILL BE INSPECTED AT REGULAR INTERVALS TO ENSURE THAT THEY ARE LABELED, INTACT, AND KEPT CLOSED.
  - H) CORROSIVES WILL BE ISOLATED FROM OTHER MATERIALS.
  - I) PROTECTIVE CLOTHING AND EQUIPMENT WILL BE AVAILABLE FOR USE WHEN HANDLING THESE MATERIALS.

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4) **DISPOSAL:**

- A) DISPOSAL OF SMALL AMOUNTS OF LIQUID CHEMICAL WASTES (60CC OR 2 OZ) MAY BE DISPOSED OF BY DILUTING 1 PART OF THE CHEMICAL WITH 100 PARTS OF WATER AND FLUSHED DOWN THE SEWER SYSTEM. THESE AMOUNTS SHOULD BE DILUTED AND FLUSHED DOWN THE SEWER AT VARYING TIMES DURING THE DAY AND APPROXIMATED ACCORDING TO THE QUALITY OF CHEMICALS NEEDING DILUTION.
- B) IN DILUTING CHEMICALS FOR FLUSHING DOWN THE SEWER SYSTEM, ALWAYS ADD THE 1 PART CHEMICAL TO THE 100 PARTS WATER. NEVER ADD WATER TO THE CHEMICAL AS THIS CAN CAUSE THE CHEMICAL TO SPLASH OUT OF THE CONTAINER.
- C) WEAR RUBBER GLOVES, A MASK, AND/OR SAFETY EQUIPMENT AS REQUIRED WHEN PREPARING LIQUID CHEMICALS FOR DISPOSAL.
- D) NO EMPTY DRUMS OR BUCKETS, OR ANY OTHER CONTAINERS THAT HAVE HELD TOXIC OR CORROSIVE CHEMICALS WILL EVER BE REUSED FOR ANYTHING. THESE CONTAINERS WILL BE DISPOSED OF AS FOLLOWS:
  - 1) WHILE WEARING PROTECTIVE GARB, WASH THE CONTAINER WITH HOT WATER AND SODA ASH OR A 5% CAUSTIC SOLUTION;
  - 2) FLUSH THE CONTAINER AND WASH TWICE MORE;
  - 3) PERFORATE TOP SIDES, AND BOTTOM OF THE CONTAINER TO PREVENT ITS BEING USED.
- E) THE ADMINISTRATOR OF THE CENTER IS RESPONSIBLE FOR ENSURING THAT PROPER PERMITS ARE OBTAINED FOR DISPOSAL OF ALL HAZARDOUS CHEMICAL WASTES GENERATED AT THE FACILITY.
- F) A CERTIFICATE OF DISPOSAL WILL BE OBTAINED FROM THE RECEIVER FOR ALL HAZARDOUS CHEMICALS DISPOSED OF OFF-SITE.

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WILDCREEK SURGERY CENTER WILL MAINTAIN AN UP TO DATE PROGRAM FOR THE PURPOSE OF COMMUNICATING TO EMPLOYEES ON HAZARDOUS CHEMICALS IN THE WORK PLACE.

**RECORD KEEPING:**

- 1) SAFETY DATA SHEETS:  
THESE WILL BE KEPT UP TO DATE WITH ALL CURRENT AND ANY NEW CHEMICALS IN THE CENTER.
- 2) EMPLOYEE SIGN OFF SHEETS:  
WHEN EMPLOYEES ATTEND THE HAZARDOUS COMMUNICATIONS PROGRAM AS PART OF THEIR ORIENTATION, THEY WILL SIGN AND DATE A FORM ACKNOWLEDGING THIS.
- 3) RESPONSIBILITIES:  
THE CENTER'S NURSING MANAGER WILL BE RESPONSIBLE FOR ASSURING THAT ALL EMPLOYEES RECEIVE THE HAZARDOUS MATERIAL INFORMATION. THE OSHA PROGRAM COORDINATOR WILL OVERSEE AND MANAGE THE PROGRAM.

THE NURSING MANAGER OF WILDCREEK SURGERY CENTER WILL BE RESPONSIBLE FOR ALL HAZARDS, RECALLS, AND ALERTS. THIS PERSON WILL COLLECT AND REVIEW ALL DATA CONCERNING DEFECTIVE EQUIPMENT, PRODUCTS AND SUPPLIES WHICH MAY AFFECT THE GENERAL SAFETY OR PRESENT A RISK TO PATIENT CARE, VISITORS, OR CENTER STAFF.

PROCEDURE: 1) THE NURSE MANAGER WILL:

- A) REVIEW ALL DATA COLLECTED FROM ALL SOURCES CONCERNING RECALLS OR ALERTS OF DEFECTIVE OR HAZARDOUS EQUIPMENT, PRODUCTS, OR SUPPLIES.
- B) INFORM THE CENTER'S ADMINISTRATOR AND MEDICAL DIRECTOR.
- C) DISSEMINATE HAZARDOUS RECALL OR ALERT INFORMATION TO APPROPRIATE MEMBERS INVOLVED IN THE UTILIZATION OF THE POTENTIAL HAZARDOUS PRODUCTS, OR SUPPLIES.

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- AND QUESTION.
- POTENTIAL
- PROTECTION OF
- D) COLLECT, COORDINATE, AND EVALUATE INFORMATION RETURNED FROM THE INVOLVED AREAS TO ASSURE ANY ACTION REQUIRED HAS BEEN ADDRESSED HANDLED TO MINIMIZE RISK ASSOCIATED WITH THE ITEM IN
  - E) MONITOR ALL OUTSTANDING RECALLS TO ASSURE THAT ALL ISSUES OR PRODUCT LIABILITIES HAVE BEEN RESOLVED TO COMPLETION.
  - F) MAINTAIN SUPPORTING DOCUMENTATION WITHIN THE CENTER.
  - G) REPORT RESULTS INCLUDING ANY ACTIONS TAKEN TO THE QAPI COMMITTEE.
  - H) TAKE IMMEDIATE ACTION AS NECESSARY TO PROVIDE THE PROPER ALL PATIENTS, VISITORS, AND STAFF MEMBERS.
  - I) CALL IN OTHER PERSONNEL TO ASSIST IN FINDING RESOLUTIONS TO IDENTIFIED ISSUES AS NECESSARY.

WILDCREEK SURGERY CENTER WILL COMPLY WITH ALL LOCAL, STATE, AND FEDERAL LAWS, RULES, AND REGULATIONS GOVERNING THE HANDLING AND DISPOSAL OF CONTAMINATED MEDICAL WASTE. THE CENTER WILL PROTECT ALL EMPLOYEES, VISITORS, AND STAFF MEMBERS FROM POSSIBLE EXPOSURE TO INFECTIOUS DISEASES THROUGH A WASTE MANAGEMENT PROGRAM.

IN ADDITION, THE CENTER WILL PROTECT THE PUBLIC AND THE ENVIRONMENT IN GENERAL BY CONTAINING ALL CONTAMINATED WASTES PRIOR TO THEIR DISPOSAL SO AS NOT TO CAUSE INFECTIOUS DISEASE TO BE SPREAD. THESE CONTAMINATED WASTES WILL BE CONTAINED AND DISPOSED OF IN A SAFE AND APPROVED MANNER.

PROCEDURE:

### **DEFINITION-INFECTIOUS MEDICAL WASTE:**

BIOHAZARDOUS WASTE IS ANY SOLID OR LIQUID WASTE WHICH MAY PRESENT A THREAT OF INFECTION TO HUMANS. THE REQUIREMENTS FOR INDUCTION OF DISEASE IS THE PRESENCE OF A PATHOGEN WITH SUFFICIENT VIRULENCE AND IN A QUANTITY SUBSTANTIAL ENOUGH SO THAT EXPOSURE TO THE WASTE BY A SUSCEPTIBLE HOST OR ORGANISM COULD RESULT IN AN INFECTIOUS DISEASE.

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### **IDENTIFICATION OF MEDICAL WASTE:**

- ISOLATION WASTE FROM PATIENTS WITH INFECTIOUS DISEASE
- CULTURES AND STOCKS OF INFECTIOUS AGENTS AND ASSOCIATED BIOLOGICALS
- HUMAN BLOOD AND BLOOD PRODUCTS; USED, ABSORBENT MATERIALS SUCH AS BANDAGES, SPONGES, AND GAUZE SUPERSATURATED WITH BLOOD OR BODY FLUIDS HAVING THE POTENTIAL TO DRIP OR SPLASH
- PATHOLOGICAL WASTE; TISSUES, ORGANS, OR BODY PARTS
- CONTAMINATED SHARPS; HYPODERMIC NEEDLES, SYRINGES, PIPETTES, BROKEN GLASS, SCALPEL BLADES, SUTURING NEEDLES, TROCHARS, ETC.

### **MEDICAL WASTE MANAGEMENT:**

- 1) THE NURSE MANAGER WILL BE RESPONSIBLE FOR THE DEVELOPMENT AND MAINTENANCE OF A MEDICAL WASTE MANAGEMENT PROGRAM.
- 2) THE WASTE MANAGEMENT PROGRAM WILL INCLUDE:
  - A) EMPLOYEE TRAINING IN MEDICAL WASTE HANDLING
  - B) MONITORING OF PROPER PACKAGING AND LABELING
  - C) FOLLOW-THROUGH ON TRACKING PROCEDURES
  - D) CONTINGENCY/EMERGENCY PLAN
- 3) ALL POTENTIALLY INFECTIOUS MEDICAL WASTE WILL BE SEPARATED FROM GENERAL FACILITY GARBAGE AT ITS POINT OF ORIGIN.
- 4) ALL POTENTIALLY INFECTIOUS MEDICAL WASTE WILL BE PLACED IN BOXES LABELED "BIOHAZARD WASTE" THAT CONSPICUOUSLY DISPLAYED THE BIOHAZARD SYMBOL. THESE BOXES WILL BE LINED WITH TWO (2) RED PLASTIC BAGS THAT ARE IMPERVIOUS, AND TEAR RESISTANT.
- 5) EACH HAZARDOUS WASTE BOX WILL NOT EXCEED A FIFTY (50) POUND MAXIMUM WEIGHT LIMIT.

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- 6) ALL FLUIDS PLACED IN THE HAZARDOUS WASTE BOX WILL BE CONTAINED; CAPS WILL BE PLACED SECURELY ON ALL PORTS OF SUCTION CONTAINERS. BULK BLOOD, SUCTIONED FLUIDS, EXCRETIONS, AND SECRETIONS MAY BE CAREFULLY POURED DOWN A DRAIN CONNECTED TO SANITARY SEWER.
- 7) ALL SHARPS WILL FIRST BE PLACED IN A PUNCTURE PROOF SHARPS CONTAINER. WHEN FILLED THE SHARPS CONTAINER WILL BE SECURELY CLOSED AND DISPOSED OF IN THE HAZARDOUS WASTE BOX.
- 8) FILLED HAZARDOUS WASTE BOXES WILL BE SECURED BY FOLDING THE INNER RED BAG OVER THE CONTENTS, THEN TWISTING THE OUTER RED BAG, CLOSED AND SECURED WITH A TIE. THE LID MUST BE ABLE TO FIT SNUGLY ON TO THE BOX; BOXES WILL NOT BE OVERFILLED.
- 9) A SECURED BIO-HAZARDOUS WASTE BOX WILL BE KEPT IN LOCKED STORAGE IN THE SOILED WORK AREA UNTIL PICKED UP. THIS AREA HAS BEEN DESIGNATED FOR CONTAMINATED WASTE CONTAINERS AND HAS RESTRICTED ACCESS BY UNAUTHORIZED PERSONS.
- 10) PICK-UP WILL BE ARRANGED ON A AS NEEDED BASIS, OFTEN ENOUGH TO PREVENT INFESTATION.
- 11) IN THE EVENT OF LEAKAGE OR ACCIDENTAL SPILL OF A HAZARDOUS WASTE BOX, PROTECTIVE ATTIRE WILL BE WORN, AND THE CONTENTS WILL BE PLACED IN AN INTACT HAZARDOUS WASTE BOX. SPILLS WILL BE CLEANED UP USING A GERMICIDAL AGENT AND DISPOSABLE TOWELS. ALL MATERIALS USED IN CLEANING THE SPILL WILL THEN BE DISPOSED OF IN A HAZARDOUS WASTE BOX; SATURATED OR DRIPPING MATERIALS WILL FIRST BE PLACED IN A PLASTIC BAG.
- 12) TRANSPORTATION OF THE FILLED HAZARDOUS WASTE BOXES OFF THE PREMISES WILL BE BY ENCLOSED, LEAK PROOF TRUCKS.
- 13) DOCUMENTATION OF PICK-UP WILL BE MAINTAINED BY THE CENTER; DOCUMENTATION OF APPROPRIATE DISPOSAL WILL BE MAINTAINED BY THE RECEIVING SERVICE AS WELL AS TRACKING OF CENTER VOLUME.
- 14) WASTE MANAGEMENT IS A STATE APPROVED BIO-HAZARDOUS WASTE DISPOSAL SERVICE, AND WILL BE UTILIZED FOR THE COLLECTION OF WILDCREEK SURGERY CENTER'S BIO-HAZARDOUS WASTE.

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- 15) POLICIES AND PROCEDURES RELATING TO THE OPERATION OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT SYSTEM WILL BE REVIEWED ANNUALLY.
- 16) THE QUALITY ASSURANCE/RISK MANAGEMENT COMMITTEE WILL BE RESPONSIBLE FOR TRACKING THE MANAGEMENT OF HAZARDOUS WASTE, SECURING REGULATIONS, AND MAINTAINING COMMUNICATION FOR OPERATION WITH WASTE MANAGEMENT.

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TITLE: **N-250 EMERGENCY GENERATOR**

POLICY: WILDCREEK SURGERY CENTER WILL MAINTAIN AN EMERGENCY GENERATOR TO PROVIDE CONSISTENT ELECTRICAL POWER TO ALL NECESSARY EQUIPMENT IN THE EVENT OF AN ELECTRICAL POWER FAILURE. THE EMERGENCY GENERATOR IS LOCATED OUTSIDE

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THE BUILDING IN THE NORTHWEST CORNER OF THE CENTER. THE CENTER WILL MAINTAIN A SERVICE CONTRACT FOR MAINTENANCE AND REPAIR WITH A LOCAL OUTSIDE AGENCY. THE CENTER WILL DO WEEKLY GENERATOR CHECKS AND A MONTHLY 30 MINUTE LOADED RUN WHICH WILL BE DOCUMENTED IN THE GENERATOR LOG BOOK.

### **PROCEDURE:**

- 1) THE GENERATOR LOG BOOK WILL BE KEPT IN THE NURSE MANAGER'S OFFICE.
- 2) THE ADMINISTRATOR WILL MONITOR TESTING OF THE EMERGENCY GENERATOR, MAINTAIN THE LOG, AND ASSURE PERIODIC TESTING IS DONE BY OUTSIDE CONTRACTOR PER SERVICE AGREEMENT.
- 3) FUEL FOR THE GENERATOR IS NATURAL GAS.
- 4) PROBLEMS ENCOUNTERED, MAINTENANCE OR REPAIRS NEEDED, OR OTHER AREAS OF CONCERN NOTED WILL BE REPORTED TO, AND TAKEN CARE OF BY THE CENTER'S ADMINISTRATOR, BUSINESS OFFICE OR NURSE MANAGER.
- 5) MAINTENANCE AND REPAIRS WILL BE SCHEDULED AND CONDUCTED ON A TIMELY BASIS.

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TITLE: **N-260 WHEELCHAIR AND STRETCHER SAFETY**

POLICY: WILDCREEK SURGERY CENTER WILL ENSURE THAT SAFETY IS A PRIORITY IN THE CARE OF PATIENTS BEING TRANSPORTED BY WHEELCHAIR OR STRETCHER THROUGHOUT OUR FACILITY

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### **PROCEDURE: WHEELCHAIR SAFETY:**

1. LEG AND FOOTRESTS SHALL BE UTILIZED AS INDICATED BY THE PATIENTS CONDITION.
2. URINARY DRAINAGE BAGS SHALL BE HUNG TO FACILITATE GRAVITY FLOW AND TO AVOID ENTANGLEMENT IN THE WHEELS OF THE CHAIR.
3. PATIENTS WITH IV'S, OXYGEN THERAPY, TUBES, EQUIPMENT, ETC., SHALL BE ASSESSED BY THE NURSING PERSONNEL BEFORE TRANSPORT.
4. UPON TRANSFER OF PATIENTS INTO AND OUT OF A WHEELCHAIR, THE WHEELS WILL BE LOCKED.
5. WHEN A PATIENT IS STATIONARY IN A WHEELCHAIR, THE WHEELS WILL BE LOCKED.
6. WHEN A WHEELCHAIR, OR ANY PART OF IT IS FOUND TO BE WORN OR DEFECTIVE, THE DEPARTMENT MANAGER WILL BE NOTIFIED AND THE WHEELCHAIR WILL BE TAKEN OUT OF SERVICE AND REPAIRED.
7. WHEELCHAIRS SHALL BE PULLED RATHER THAN PUSHED OVER DOORWAY ELEVATION CHANGES AND EXTREMITIES SHALL BE POSITIONED TO PREVENT INJURY UPON TRANSPORT.

### **PROCEDURE: STRETCHER SAFETY**

1. UPON TRANSFER FROM THE OPERATING ROOM TABLE TO THE STRETCHER, OR OPPOSITE, THE LEVEL SHALL BE EQUAL.
2. THE WHEELS OF THE STRETCHER AND OPERATING ROOM TABLE SHALL BE LOCKED BEFORE TRANSFER
3. ALL IV BAGS AND TUBING, OXYGEN TUBING, DRAINAGE TUBING, DEVICES, ETC., ATTACHED TO THE PATIENT SHALL BE ARRANGED AND SECURED BEFORE TRANSPORT.
4. TRANSPORT PATIENTS FEET FIRST ON STRETCHERS WITH THE SIDE RAILS UP.
5. IN THE EVENT THAT ONLY ONE PERSON IS PERFORMING THE TRANSPORT OF A STRETCHER THAT PERSON SHALL BE AT THE HEAD OF THE STRETCHER.
6. PROTECT PATIENTS EXTREMITIES UPON TRANSPORTING THROUGH DOORWAYS.

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### **TITLE: N-270 LIFTING AND MOVING SAFETY**

**POLICY:** WILDCREEK SURGERY CENTER WILL ENSURE THE MAINTENANCE OF EMPLOYEE AND PATIENT SAFETY AS PRIORITIES IN THE WORK PLACE.

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## **POLICIES AND PROCEDURES**

**PROCEDURE:** THE CENTERS WORK ENVIRONMENT CONTAINS TASKS THAT REQUIRE HEAVY LIFTING AND MOVING OF PATIENTS, EQUIPMENT, AND SUPPLIES. BACK INJURY AND HERNIAS ARE THE MOST COMMON RESULTS OF IMPROPER BODY MECHANICS AND LIFTING TECHNIQUES. ALL EMPLOYEES WILL BE RESPONSIBLE FOR KNOWING AND UTILIZING PROPER BODY MECHANICS TO PREVENT AND AVOID SUCH INJURIES.

### **LIFTING AND MOVING GUIDELINES:**

1. UTILIZE MECHANICAL DEVICES FOR LIFTING PATIENTS OR HEAVY OBJECTS WHEN APPROPRIATE
2. UTILIZE APPROPRIATE CARTS FOR TRANSPORTING HEAVY OBJECTS
3. ENLIST THE HELP OF A CO-WORKER WHEN LIFTING HEAVY OBJECTS OR PATIENTS
4. CARRY THE LOAD IN A MANNER THAT PERMITS YOU TO SEE WHERE YOU ARE GOING
5. CARRY THE LOAD THE SHORTEST POSSIBLE DISTANCE
6. KEEP THE BACK STRAIGHT
7. THE LOAD SHALL BE BALANCED AND CARRIED WITH A FULL PALM GRIP
8. THE LOAD SHALL BE CARRIED CLOSE TO THE BODY
9. DO NOT ATTEMPT TO CARRY A LOAD THAT IS TOO HEAVY OR BULKY
10. UTILIZE LEG AND ARM MUSCLES TO DO THE LIFTING, NOT YOUR BACK
11. MAINTAIN A WIDE LEG STANCE WHEN LIFTING
12. A CD IN-SERVICE EDUCATION CONCERNING PROPER BODY MECHANICS IS AVAILABLE.

SECTION: N SAFETY

DATE: 04/10

REVIEWED: 3/12, 5/16

TITLE: **N-280 FIRE WATCH**

# ***WILDCREEK SURGERY CENTER***

## **POLICIES AND PROCEDURES**

**PURPOSE:** To establish a plan of action should the fire alarm system **or** sprinkler system be out of service for more than 4 hours in a 24-hour period. (Procedures must address both the fire alarm and sprinkler systems.)

**ACCESS:** Available in writing at staff stations and comprehended by training of all facility staff.

**STAFF:** Facility staff trained in Rescue, Alarm, Contain, and Extinguish/ Evacuate (RACE) and the implementation of a facility-wide fire watch.

**DOCUMENTATION:** Each tour is recorded with findings noting date time, and staff initials. A fire watch tour is a periodic walking tour of the entire facility by one or more assigned and trained staff. This **MUST BE** staffs **ONLY** responsibility during the Fire Watch. The tour monitors the facility through direct observation of all rooms for possible signs of fire.

**OCCURANCES:** Fire alarm system outages or sprinkler system outages can occur during construction, maintenance, renovation, electrical storms or other unplanned events which eliminate part or all of the fire alarm system. Sprinkler systems may also be made inoperable by a variety of planned and unplanned events.

### **PROCEDURE:**

1. Contact the facility administrator, nurse director and business office manager when any problems are encountered with the fire alarm system or sprinkler system.  
(Action: staff)
2. Contact the fire alarm or sprinkler contractor at (775) 823-7300 should maintenance be unable to correct the problem.  
(Action: nurse director or business manager).
3. Contact the facility alarm company at (888) 289-2647 should maintenance be unable to correct the problem.  
(Action: nurse director or business manager).
4. Fire alarm or sprinkler contractor shall be on site or on contract until system is repaired, replaced or reinitialized and working.
5. Notify the fire department at (775) 353-2255 that the sprinkler system or fire alarm system is not working correctly.  
(Action: administrator/nurse director/ business manager).
6. If the sprinkler or fire alarm system is inoperable for a time period of more than 4 hours in a 24 hour period, notify the Nevada Department of Health District Office. They can be contacted at (775) 688-2811.  
(Action: administrator/ nurse director/business manager).
7. Fire watch procedure shall designate facility tours designating floor and building identifier.  
(Action: Facility Administrator/ nurse director)
8. Fire watch tours shall occur at ¼ hour intervals, 24 hours a day.  
(Action: Facility Administrator/ nurse director)

**WILDCREEK SURGERY CENTER**

POLICIES AND PROCEDURES

**NOTICE**

THE BUILDING FIRE ALARM SYSTEM IS  
INOPERATIVE

FROM \_\_\_\_\_ TO \_\_\_\_\_

*EVERY EFFORT IS BEING MADE TO COMPLETE THE REPAIRS AS SOON AS POSSIBLE.*

*IMMEDIATELY CONTACT 775-674-1100 IF YOU DETECT ANY OF THE  
FOLLOWING:*

- *SEE OR SMELL, OR*
- *DETECT THE PRESENCE OF FIRE, OR*
- *SMELL NATURAL GAS, OR*
- *DETECT THE PRESENCE OF ANY OTHER CONDITION  
WHICH ENDANGERS THE LIFE OF BUILDING OCCUPANTS.*



WILDCREEK SURGERY CENTER

POLICIES AND PROCEDURES

FIRE WATCH LOG

| <u>DATE</u> | <u>TIME</u> | <u>AREA</u><br><u>COMPROMISED</u> | <u>INITIALS</u> |
|-------------|-------------|-----------------------------------|-----------------|
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**WILLIAM BEE RIRIE CRITICAL ACCESS HOSPITAL/RURAL HEALTH CLINIC**

**ADMINISTRATION POLICY & PROCEDURES**

**Department: Risk Management**

**Program/Manual: Patient Safety**

**Policy Subject: Patient Safety Plan**

**Section Number: P**

**Effective Date: 11-5-2007**

**Revision Date: 12-3-2013, 2-11-2015, 02-2019**

**Review Date: 02/01/2020**

**I. INTRODUCTION**

The Patient Safety Program supports and promotes the mission, vision and values of William Bee Ririe Hospital and Rural Health Clinic through organizational prioritization of patient, visitor and employee safety.

The patient safety program is implemented through the Enterprise Safety Committee and is supported by leadership's promotion of a safety culture that:

- Encourages recognition, reporting, and acknowledgment of risks to patient/visitor and employee safety and medical/healthcare errors
- Initiates/monitors actions to reduce risks/errors
- Internally report's findings and actions taken
- Promotes a blame-free culture facilitating the reporting and follow-up on safety concerns, errors and adverse events
- Educates staff and physicians to assure participation in the program

**II. PURPOSE**

The Patient Safety Program is designed to enhance patient care delivery and prevent adverse outcomes of care by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach focuses on actual and potential occurrences; ongoing proactive risk management; and integration of patient safety priorities in the development and revision of processes, functions and services.

**III. MISSION, VISION AND VALUES**

In support of the mission, vision and values of this organization the Patient Safety Program promotes;

- Collaboration among staff members, physicians and other providers to deliver comprehensive, integrated and quality health care.
- A focus on comprehensive, integrated quality service

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- Open and honest communication to foster trust relationships among staff members, physicians, other providers and patients.

#### IV. OBJECTIVES

The objectives of the Patient Safety Program are to:

- Encourage organizational learning about adverse or potential adverse events
- Incorporate recognition of patient safety as an integral job responsibility
- Provide patient safety education
- Involve patients in decisions about health care and promote open communication
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate proactive measures
- Report internally any findings and actions taken to reduce risk
- Support sharing of knowledge to effect change
- Supplying support systems to health care workers who are involved in sentinel events.
- Have a sufficient number and mix of individuals to support safe, quality care, treatment, and services.

#### V. RESPONSIBILITIES/DUTIES

It is William Bee Ririe Hospital and Rural Health Clinic's responsibility to designate an officer or employee of the facility to serve as the patient safety officer of the medical facility.

The duties of the designated patient safety officer are:

- To serve as the patient safety officer of WBRH and RHC
- Serve on the Enterprise Safety Committee
- Supervise the reporting of all incident reports and/or sentinel events alleged entered in CCD Health Systems (Electronic QRR) to have occurred at the WBRH and RHC, including, without limitation, performing required pursuant to NRS 439.835
- Duties pursuant to 439.835 are
  - a) A person who is employed by WBRH and RHC shall, within 24 hours after becoming aware of a sentinel event that occurred at WBRH and RHC, notify the patient safety officer of the sentinel event.
  - b) The patient safety officer shall, within 13 days after receiving notification, report the date, the time and a brief description of the sentinel event to The Health Division and facility representative if that person is different from the patient safety officer.

- c) If the patient safety officer of WBRH and RHC personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at WBRH and RHC, the patient safety officer shall, within 14 days after discovering or becoming aware of the sentinel event report the date, time and brief description event to those listed in b) above.
- Take such action as he or she determine to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at WBRH and RHC
- Report to the Enterprise safety committee regarding any action taken in accordance to the above paragraph.

The Enterprise Safety Committee shall meet monthly.

The Patient Safety Plan and any changes thereafter shall be presented to the governing board of WBRH and RHC for approval.

The Patient Safety Plan must include, without limitation, the patient safety checklists and patient safety policies most recently adopted in regards to the patient safety plan.

After the WBRH and RHC's patient safety plan is approved, WBRH and RHC shall notify all providers of health care who provide treatment to patients at WBRH and RHC of the existence of the plan and of the requirements of the plan. WBRH and RHC shall require compliance with the patient safety plan.

The Enterprise safety Committee shall

- Receive reports from the Patient Safety Officer
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the facility
- Review and evaluate the quality of measures carried out by WBRH and RHC to improve the safety of patients who receive treatment at WBRH and RHC
- Make recommendations to the governing body of WBRH and RHC to reduce the number and severity of sentinel events that occur at WBRH and RHC.

The Enterprise Safety Committee provides a multidisciplinary forum for the collection and analysis of risk to patient safety and the dissemination of information on identified risk for the purpose of improving patient care. It shall review reports on occurrences including near misses to sentinel events. It shall identify those individuals or groups best situated to perform a root cause analysis and develop and implement an action plan for identified issues. It shall review, analyze and disseminate the information it receives, as appropriate, to the designated individuals and/or committees. It shall provide recommendations

concerning identified risks, approve plans for corrective actions and evaluate the implantation of corrective actions taken.

Membership may include representatives from administration, providers, clinical and support staff. Membership shall have at least 3 providers of healthcare who treat patients at WBRH and RHC, including without limitation, at least 1 member of the medical, 1 member of nursing and 1 pharmaceutical staff, member and 1 member of the governing body.

## VI. SCOPE

The types of occurrences to be addressed include, but are not limited to, sentinel events, near misses, and actual events related to:

- a) Patient safety
- b) Adverse drug events (medication errors and adverse drug reactions)
- c) Health acquired infections
- d) Patient Falls
- e) Other patient incidents/unexpected clinical/medical events
- f) Unsafe conditions
- g) Visitor safety
  - Visitor incidents
- h) Employee safety
  - Blood/body fluid exposures
  - Occupational diseases
  - Communicable disease exposures
  - Musculoskeletal injuries
  - Immunization programs
  - Other employee incidents
- i) Environmental safety
  - Product recalls
  - Drug recalls
  - Product/equipment malfunction
  - Construction
  - Infection Control Risk Assessment
  - Water Quality
  - Air Quality
  - Disaster Planning
  - Security incidents
  - Workplace violence

Data from external sources, including but not limited to:

- Centers for Disease Control and Prevention (CDC)
- Joint Commission
- Institute for Healthcare Improvement (IHI)
- Institute for Safe Medication Practices (ISMP)
- Occupational Safety and Health Administration (OSHA)
- Nevada State Health Division
- Published literature

## VII. DEFINITIONS

Serious Reportable (Sentinel) Event is defined by NRS 439.830 and means an event included in Appendix A of "Serious Reportable Events in Healthcare". The seven (7) Serious Reportable Events along with their subsets are as follows:

### Specifications of the Serious Reportable Events in Healthcare

#### 1. Surgical or Invasive Procedure Events

- A. Surgery or other invasive procedure performed on the wrong site
- B. Surgery or other invasive procedure performed on the wrong patient
- C. Wrong surgical or other invasive procedure performed on a patient
- D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- E. Intraoperative or immediately post-operative/post-procedure death in an ASA Class 1 Patient

#### 2. Product or Device Events

- A. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting
- B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
- C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

#### 3. Patient Protection Events

- A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
- B. Patient Death or serious injury associated with patient elopement (disappearance).
- C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.

#### 4. Care Management Events

- A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).

- B. Patient death or serious injury associated with unsafe administration of blood products
- C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
- D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.
- E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting.
- F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting.
- G. Artificial insemination with the wrong donor sperm or wrong egg.
- H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
- I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

#### 5. Environmental Events

- A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting.
- B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances.
- C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting.
- D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

#### 6. Radiologic Events

- A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

#### 7. Potential Criminal Events

- A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- B. Abduction of a patient/resident of any age.
- C. Sexual abuse/assault on a patient or staff within or on the grounds of a healthcare setting.
- D. Death or serious injury of a patient or staff member from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

### VIII. STRUCTURE

The authority for the Patient Safety Plan rests with the CEO, CNO, Quality Improvement Coordinator, Patient Safety Officer, and Chief of Medical Staff and has delegate the authority to implement and maintain activities described in this plan to the Enterprise safety committee.

## IX. QUALITY REVIEW INFORMATION

To the extent possible, and in the manner consistent with the protection of confidentiality of quality assurance and patient safety data, pertinent information will be shared between the Quality Improvement Program and the Enterprise Safety Program.

In an attempt to protect quality review information from discovery, all quality review documents must be labeled as a Quality Review document. Documents should be in a formal format, handled by a limited number of individuals and secured in the Quality or Risk Managers Office accessible only to designated individuals. Nevada Revised Statute that protects quality documents is NRS49.265.

## X. EDUCATION

Annual Staff and physician/provider education includes but is not limited to the following topics:

- Fire Drills
- Emergency and Disaster Drills
- Workplace violence
- Customer Service
- Creating, implementing, achieving, and maintaining a culture of Enterprise safety
- Risk management and error prevention
- Teamwork

## XI. SAFETY IMPROVEMENT ACTIVITIES

Specify Measures Selected for an annual focus; (Examples are listed below)

- Patient satisfaction surveys
- Medical Record review; legible documentation, clear, complete, signed
- Complaints and resolution; to improve care and satisfaction (trends)
- Confidentiality; insure patient and employee information is secure
- Appointments/scheduling process; accessibility to physician
- Informed Consent Policy and Procedure
- Medication management and reconciliation i.e. current allergy information
- Telephone response time to callers
- Occurrence review

Give consideration to measures that facilitate safe practices; (Examples are listed below)

- Involve patients in their health care; consider literacy issues and cultural values, partner with patients in developing and planning their care plan.



- Use a team approach to safety; hold focused safety meetings
- Endorse open, effective communication; identify shared values and attitudes among all members. Interview and/or survey staff for attitudes, perceptions and communication barriers.
- Encourage error reporting to include near miss events. Institute a non-punitive reporting that is confidential and timely.
- Ensure employee and patient information or event reports shared with staff for educational purposes do not identify individuals.
- Facilitate communication skills learning (teamwork)
- Examine physical premises to identify and correct potential hazardous conditions.
- Orient physicians and new employees to risk management and patient safety concepts
- Conduct patient safety rounds
- Provide education and training on high risk processes.

## XII. METHODOLOGY

### A. Structure

- Proactive risk prevention strategies
- Identification of High Risk Areas
- General Incidences (Patient Injuries)
- Potential or actual adverse events (medication errors)

### B. Method – Establish a process for;

- Identification, Selection, Prioritization
- Data Collection and Analyses
- Development of Actions
- Implementation
- Reporting
- Follow-up

### C. Process Improvement – Establish teams/individual staff members to implement processes and to monitor for effectiveness.

Utilize applicable tools to facilitate improvement; for example

- PDCA: Plan, Do Check Act with focus on process improvement
- FMEA: Failure Mode Effect Analysis is a systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk.
- RCA: Root Cause Analysis is a retrospective approach to error analysis that identifies what and how the event occurred and why it happened. The focus is on the process and systems not individuals.

## XIII. PROGRAM EVALUATION

The Patient Safety Officer will submit monthly a report the Enterprise Safety Committee, Medical Staff and the Board of Directors

1. Definition of the scope of occurrence including sentinel events, near misses and serious occurrences that occurred at WBRH and RHC during the preceding month including;
  - Employee injuries
  - Potential lawsuits
  - Resolutions
  - Recommendations to the decrease of the number and severity of Sentinel Events

Yearly the Patient Safety Officer will submit to the Enterprise Safety Committee, Medical Staff and the Governing Board the following;

- a. Detail of activities that demonstrate the enterprise safety program has a proactive component by identifying the high-risk process selected.
- b. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis.
- c. A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles.
- d. The results of how input is solicited and participation from patients and families in improving patient safety is obtained.
- e. The results of the program that assesses and improves staff willingness to report errors.
- f. A description of the examples of ongoing education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

Yearly the Enterprise Safety Committee shall;

1. Monitor and document the effectiveness of the patient identification policy.
2. Review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
3. Revise a patient safety checklist and patient safety policy adopted as necessary to ensure that the checklist or policy reflects the most current standards in patient safety protocols.
4. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. This report must contain;

- Information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

#### XIV.NO CRIMAL PENALTY OR CIVIL LIABILITY

No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if the person, without malice;

- Reports sentinel event to a governmental entity with jurisdiction or another appropriate authority.
- Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event.
- Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority
- Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or
- Performs any other act authorized pursuant to NRS 439.800 to 439.890.

NRS439.860 ANY REPORT, DOCUMENT AND ANY OTHER INFORMATION COMPILED OR DISSEMINATED PURSUANT TO THE PROVISIONS OF NRS 439.800 TO 439.890, INCLUSIVE AND SECTION I OF AB 280 IS NOT ADMISSIBLE AS EVIDENCE IN ANY ADMINISTRATIVE OR LEGAL PROCEEDING CONDUCTED IN THE STATE OF NEVADA.