Banner Health

TITLE: Banner Health Quality and Safety Plan	
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Type: Administrative - Improving Organizational Performance	Author: Mikaela Mackey (Care Management Performance Improvement Team)
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Facility: System	
Population (Define): All Employees	
Replaces: Patient Safety Plan (#5800)	
Approved by: Care Management Council, Senior Operations Team, BH Board of Directors Quality Committee, BH Board of Directors	

TITLE: *Banner Health Quality and Safety Plan*

I.   Purpose/Expected Outcome:

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, Core Behaviors and Vision. 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 physicians, our communities and ourselves.

B. Mission: The mission of Banner Health is to make a difference in people's lives through excellent patient care.

C. Values and Core Behaviors: Banner's Values define the culture of Banner Health and how these values are demonstrated through actions and behaviors:

1. People Above All: We treat those we serve and each other with compassion, dignity and respect.
    a. Patient Centered
        i.   Compassionate
        ii. Respectful
        iii. Responsive
    b. Collaboration
        i.   Promotes Teamwork
        ii. Fosters Cross Departmental Coordination
        iii. Effectively Communicates

2. Excellence: We act with integrity and strive for the highest quality and service.
    a. Ownership
        i.   Proactive
        ii. Resourceful
        iii. Responsible
    b. Continuous Improvement
        i.   Safe and Reliable
        ii. Shares Knowledge
        iii. Continual Learner

3. Results: We meet the expectations of the people we serve and the expectations we set for ourselves.
    a. Outcome Focused

   b. Performance Driven
   c. Agile
   d. Accountable

D. Vision: We will be a national leader recognized for clinical excellence and innovation, preferred for a highly coordinated patient experience, and distinguished by the quality of our people.

E. Guiding Principles: Banner Health's approach to quality and patient safety is based on the following principles:
1. Patient/Customer Focus
   a. We are committed to meeting and exceeding the expectations of those we serve and engaging patients and their families in their care and services provided.
2. Leadership
   a. Our quality and patient safety commitment is established and demonstrated by our leaders.
3. Teamwork
   a. We actively encourage and involve everyone in the organization to communicate and work together to meet the needs of those we serve.
4. Continuous Improvement
   a. We understand that our outcomes are a result of our processes and that improving outcomes requires improving processes.
5. Evidence-based decision-making
   a. We rely on data from our own sources as well as credible research done elsewhere as the basis for our decisions.
6. Clinical Innovation
   a. We utilize the rapid identification and deployment of strategies leveraging Banner's operating model and the science of care delivery to ensure an extraordinary patient experience, which is safe, efficient and effective.
7. Values and Core Behaviors
   a. Our values and core behaviors set us apart as a leader in health care delivery and are essential to deliver an excellent care experience.
8. Culture of Safety
   a. Quality and patient safety is a core responsibility for all staff. We promote a culture of safety which encourages, instills and inspires accountability and responsibility.
   b. Banner Leadership support staff involved in medical incidents.
9. Learning
   a. We encourage organizational learning and support sharing knowledge within Banner Health and other health care organizations to improve quality and patient safety.

II. Definitions:

A. Facility – Any Banner Health hospital, ambulatory surgery center, physician/provider office, home health, hospice, skilled nursing facility, clinic or other setting where care is provided.

B. Process Owner – A process owner is an individual responsible for their respective level of business operations. A level of business operation could include a whole Facility, a department or a specific service within a department or across a Facility or the organization.

C. Process Improvement (PI) – Process Improvement is a series of actions taken to identify, analyze and improve existing processes to meet new goals and objectives.

D. Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management Program Activities – For the purpose of this plan, "Quality Assurance/Quality Improvement/Clinical Process Improvement/Quality Management Program" means activities designed and implemented to improve the delivery of care and services.

III. Policy:

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

B. Quality Authority/Responsibility
  1. Governance.
      a. The Banner Health Board of Directors has the ultimate responsibility and accountability for quality of care and services provided by Banner Health. The Care Management Council and the Care Management and Quality Committee of the Board serve as the oversight bodies for quality management and have the following duties and delegated responsibilities:
          i. Monitor non-financial measures of organizational quality performance.
          ii. Ensure use of a systematic approach to quality management and assess ongoing improvement in the quality of services delivered by the corporation.
          iii. Review and make recommendations to the Board regarding a system-wide quality plan.
          iv. Evaluate and make recommendations to the Board concerning healthcare technologies including, but not limited to, genomics, biotechnology, future clinical services delivery and therapeutics.
          v. Evaluate and make recommendations to the Board with respect to ethical implications relating to the activities and services of the corporation, including quality and clinical innovation.
          vi. Act for the Board with respect to proposals of management and the local institutions and their medical staffs concerning medical staff policies, patient care policies, and compliance with standards of government and accreditation agencies having jurisdiction over the corporations' institutions as to such policies which require the involvement of the Board of Directors.
          vii. Act for the Board of Directors on matters and activities pertaining to the medical staffs of each local institution operated by the corporation to the extent permitted by law and applicable accreditation standards, including any matter which requires action by the Board of Directors, including the adoption, amendment or repeal of medical staff bylaws, rules and regulations, and medical credentialing criteria.
          viii. Act for the Board of Directors to the extent permitted by law and applicable accreditation standards, and otherwise make recommendations to the Board of Directors on any matter affecting medical staff membership or privileges, including application for appointment to the medical staff; application for reappointment to a medical staff; request for delineated clinical privileges; and denial, curtailment, limitation or revocation of any of the foregoing.
          ix. Review reports regarding the quality of care being provided in respective Facilities.
          x. Perform such other duties and responsibilities as the Board may assign to the Committee from time to time.
      b. In some communities, Advisory Boards provide advice and counsel to management and medical staff leadership on a variety of issues, including quality and safety activities and outcomes.

2. Leadership.
   a. Leadership is responsible for setting organizational direction and does this through the establishment of mission, vision, and goals, including annual initiatives. These are turned into actions though 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 Care Management Council, 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 though 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.

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 outcome, 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 results, 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 these data over time, using an understanding of variation principles. Process owners are responsible for continuously standardizing and simplifying processes to increase reliability through the reduction of variation and waste. They are also responsible for proactively recognizing and implementing proven or evidence-

based practices for existing processes, using current literature sources and benchmarking activities internally as well as externally.

F. If processes are unstable, process owners investigate and work to remove the cause of the variation. If the variation results in a significant event, they are analyzed and acted on according to policy.

G. When data indicates a need to identify and correct the root cause of a problem, or there is an opportunity to move to a new level of performance, improvement projects are established. In these cases, teams, formal and informal, apply improvement processes that systematically move through the following five steps:
    1. Define the project
    2. Measure current performance
    3. Analyze to identify causes
    4. Improve
    5. Control

H. To assure that the changes required for improvement are successful, the human aspects of change are also addressed using a change model that addresses the need for effective change leadership, creating a shared need, shaping a shared vision, mobilizing commitment, implementing the change monitoring results, and anchoring the change in systems and structure.

I. Communication of improvement opportunities, new processes or practices are reported up and down the organization through defined reporting structures which include department, Facility and system-wide councils.

J. When current processes are not able to achieve customer expectations and/or established performance goals, new processes and services are designed and implemented utilizing evidence-based and innovative practices. A systematic approach involves multiple departments and disciplines working collaboratively, using information from patients, staff, payors, 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, safety surveys 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 appropriate federal and state statutes.

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.

IV. Procedure/Interventions:
A. N/A

V.   Procedural Documentation:
A. N/A

VI.   Additional Information:
A. N/A

VII.   References:
A. Alaska Statutes: § 18.23.030
B. Arizona Statutes: A.R.S. § 36-401 et seq. A.R.S. § 36-2401 et seq.
C. California Statues: Cal.Health & Safety Code § 101848.9D.
D. Colorado Statutes: C.R.S.A. § 25-3-109
E. Nebraska Statutes: Title 172 NAC, Chapter 5
F. Nevada Statutes: NRS 439.865
G. Wyoming Statutes: W.S. 35-2-910
H. CMS Conditions of Participation
I. The Joint Commission

VIII.   Other Related Policies/Procedures:
A. Banner Health Strategic Initiatives/Plan
B. Facility Work Plans
C. Event Reporting Policy (#9062)
D. Patient Complaint, Discrimination and Grievance (#2865)

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)

Banner Health Quality and Safety Management Model

Process Owners	Leadership	Teams

Leadership:
Set Organizational Direction and Strategy
↓
Establish Quality and Patient Safety Goals

Process Owners:
Understand Customer Needs and Expectations
↓
Understand Key Processes: Standardize and Simplify
↓
Establish Measures; Monitor Assess and Analyze
↓
Need to Reach New Level, Find Root Cause?

— No →

Leadership:
Oversee and Evaluate Activities, Results

— Yes →

Determine Appropriate Improvement Approach. Design new process(s) including Evidence-based Practices, Safety by Design and Innovation.

→

Teams:
Make Improvements

(Figure 2)

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                        ┌─────────────────────┐
                        │   Banner Health     │
                        │ Board of Directors  │
                        └─────────────────────┘
                                  │
                        ┌─────────────────────┐
                        │   Banner Health     │
                        │ Senior Management   │
                        │       Team          │
                        └─────────────────────┘
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- Banner Health Board of Directors
- Banner Health Senior Management Team

Facility Sr. Leadership

Quality and Safety Plan

Care Management Council

Quality and Safety Plan, Workplan & Structure

Quality/Safety Council

Medical Executive Committee

System Functional Teams | Strategic Initiative Workgroups | Clinical Performance TRIaDs | Clinical Consensus Groups

Department/Service Line Quality

PI Teams

Patient Safety

Shared Leadership

Initiative Teams

Regulatory Teams

Banner <Facility> Reporting Structure

Banner <Facility> MEC Reporting Structure

BATTLE MOUNTAIN GENERAL HOSPITAL
CRITICAL ACCESS HOSPITAL
535 S. Humboldt St.
Battle Mountain, NV 89820

Developed By: **Chief Compliance Officer**

Department: **Quality Improvement/Risk Management**
Reviewed: **June 22, 2015**

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TOPIC: PATIENT SAFETY PLAN

POLICY:
In compliance with NRS 439.800-439.890, Battle Mountain General Hospital shall develop, in consultation with the providers of health care 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.

Pursuant to NRS 439.860, any report, document and any other information compiled or disseminated pursuant to the provisions of NRS 439.800-439.890, inclusive, is not admissible in evidence in any administrative or legal proceeding conducted in this State.

The BMGH Patient Safety Plan must include, without limitation:
   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.
      2) Facility-specific infection control developed under the supervision of a the person who has successfully completed a nationally recognized basic training program in infection control, which may include, without limitation, the program offered by the Association for Professionals in Infection Control and Epidemiology, Inc.

The program to prevent and control infections within the medical facility must provide for the designation of a person who is responsible for infection control when the infection

control officer is absent to ensure that someone is responsible for infection control at all times.

Battle Mountain General Hospital shall submit its patient safety plan to its governing board for approval. After the BMGH Patient Safety Plan is approved, BMGH shall notify all providers of health care who provide treatment to patients at BMGH of the existence of the plan and of the requirements of the plan. BMGH shall require compliance with its patient safety plan. The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

BMGH shall designate an officer or employee of the facility to serve as the patient safety officer of the medical facility. The person who is designated as the patient safety officer shall:
   a) Serve on the Patient Safety Committee.
   b) Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
   c) Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred a the medical facility.
   d) Report to the patient safety committee regarding any action taken in accordance with paragraph (c).

BMGH shall establish a patient safety committee.
   a) The BMGH 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 BMGH, 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 BMGH to improve the safety of patients who receive treatment at the medical facility.
       4) Make recommendation to the executive or governing body of the medical facility to reduce the number and severity of sentinel events that occur at BMGH.
       5) At least once each calendar quarter, report to the BMGH executive or governing body of the medical facility regarding
           i. The number of sentinel events that occurred at BMGH 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.

6) Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patients safety committee determines necessary.

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 BMGH;

b) Other personnel of the medical facility who provide treatment or assistance to patients;

c) Employees of the BMGH who do not provide treatment to patients but whose duties affect the health or welfare of the patients at BMGH, including, without limitation, a janitor of BMGH; and

d) Persons with whom BMGH enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at BMGH.

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

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 and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
c) Revise a patient safety checklist and patient safety policy as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
d) On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. The report must include information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

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 to NRS 439.800-439.890 inclusive.

2016 PATIENT SAFETY PLAN FINAL

GOALS

Derived from the mission, vision and values of UHS and West Hills Hospital, the West Hills Hospital Patient Safety Plan is designed to:

- improve patient health and safety;
- provide a frame work that facilitates a culture of patient safety;
- reduce risk of error and harm; and
- Report and act upon avoidable errors, near misses, and injuries during hospitalization and outpatient treatment.
- Review all best practices through alerts and updated standards from all corporate, certification and regulatory bodies.

OBJECTIVES

The objectives of the Patient Safety Plan are to:

- Effect behavioral changes that support patient safety, risk reduction, and a living value of respect for the dignity of patients.
- Incorporate recognition of patient safety as an integral job responsibility
- Encourage recognition and reporting of patient care errors, near misses, and risks
- Assure reporting of all sentinel events in compliance with Nevada Revised Statutes (NRS) 439.870
- Assure compliance with NRS 439.875 by adopting/utilizing patient safety checklists.
- At least annually, review the checklists and policies to ensure the checklists or policy reflects the most current standards in patient safety protocols.
- Revise as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.
- Assure completion of intensive analysis of all sentinel events using the Joint Commission format and forms, taking into consideration all 6 important variables as potential causes (human, environmental, external, human resources, information management, and leadership)
- Assure development and effective implementation of appropriate action plans resulting from RCA(s).
- Implement and maintain systems which support safe patient care processes and procedures
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions and ongoing monitoring
- Monitor and document the effectiveness of the patient identification policy
- On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau.
- Report internally to the Patient Safety Council/ Committee, MEC and the Governing Board.

PRIORITIES

Priorities for 2016 are:

1. A Patient Safety Council/Committee in compliance with NRS 439.875
2. Review and evaluate the hospital's quality measures in place
3. Reduce the number and severity of sentinel events.
4. Review and modify organizational processes to ensure compliance with the Joint Commission 2016 National Patient Safety Goals
5. Analysis of one high-risk process for proactive risk assessment (FMEA commenced in 2015) Fall Prevention Program to be continued in 2016.
6. Review annually the Discharge Process Checklist or policy to ensure the most current standards in patient safety protocols are being adhered to with audit revision.
7. Implement all risk alerts to incorporate best practices to the greatest degree possible into the patient safety process and systems already in place.
8. Review, revise and promote patient-safety orientation and education for employees
9. Communicate WHH patient safety commitment to customers, patients and visitors
10. Report quarterly to the WHH Medical Staff (MEC) and at a minimum of annually to the Governing Board the results of progress towards patient safety risk and hazard reduction for the purpose of oversight

ORGANIZATION AND FUNCTIONS

The **Patient Safety Council** is a standing interdisciplinary group that manages the organization's Patient Safety Program through a systematic, coordinated, continuous approach. The council will meet monthly, no less than 10 times per year, to assure the maintenance and improvement of Patient Safety. Membership is required to attend 10 of the 12 meetings held during each year.

1. The scope of the Patient Safety Council includes review and analysis of actual and potential patient care errors involving the patient population of all ages, visitors, hospital/medical staff, and students. Data from internal (PI/RM data collection, incident reports, patient/family complaints, patient satisfaction surveys, Core Measure reports, employee and medical staff suggestions, infection Prevention and external resources (TJC Sentinel Event Alerts, UHS alerts and advisories , customer feedback, licensure and/or accreditation survey results, reports in the literature, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. Best Practices will be researched and reviewed for possible implementation.

2. Definitions related to patient care errors include:

   - Adverse Event – Any injury caused by health care; an undesirable outcome resulting from some aspect of diagnosis or treatment
   - Error Chain – A series of events leading to an undesirable outcome

- FMEA (Failure Mode Effects Analysis) – A framework for predicting possible errors, particularly process failure, is combined with an estimate of the relative impact of that error to produce a "criticality index". This index allows for prioritization of quality improvement targets
- Hazardous Conditions – any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome
- Near Miss – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome; a "close call"
- Patient Safety – Freedom from accidental or preventable injuries produced by healthcare
- Root Cause – cause of process variation including (1) failure to follow standard operating procedures; (2) poor leadership; (3) breakdowns in communication or teamwork; (4) overlooking or ignoring individual fallibility; and (5) losing track of objectives.
- Sentinel Event – new definition as of October 1, 2013 per Nevada Revised Statute. An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome
- GOOD Catch Program will document and implement strategies to provide a safe environment for our patients.

3. The **Patient Safety Council** will be chaired by the designated **Patient Safety Officer**.

   a. The Patient Safety Council report will be presented by the Director of Performance Improvement / Risk Management.

   b. The responsibilities of the Patient Safety Officer include:

      i. Serving on the Patient Safety Council/Committee;
      ii. Supervision of the reporting of all sentinel events alleged to have occurred in the hospital;
      iii. Taking such action as he/she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event; and
      iv. Reporting to the Patient Safety Committee regarding any action(s) taken.

   c. Team membership includes (as required by law) in Nevada NRS: at least 3 healthcare providers, including a minimum of one member of the medical staff, nursing, and pharmaceutical staff of the hospital, the infection preventionist (as required by NRS) and one member of the Governing Board. The CEO and Patient Safety Officer also will be voting members, as

required by law. Other organization leaders will be invited to participate on an as-needed basis.

4. The mechanism to insure all components of the organization are integrated into the program is via a collaborative effort throughout the hospital and outpatient services.

This is accomplished by:

- Reporting of potential or actual occurrences through the Incident Reporting system utilizing the Healthcare Peer Review (HPR) format by any employee in all departments.
- Analysis of complaints or suggestions from patients and families.
- Obtaining employee and medical staff suggestions for improvements via Process Improvement submissions.
- Integration of Infection Prevention data in coordination with the infection preventionist.
- Consideration of ages and developmental levels of the patient populations.
- Communication between the Patient Safety Officer and the Environment of Care Safety Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.
- Reporting of patient safety measurements to the performance improvement coordinating and oversight group.
- Review of processes, policies and systems in place as alerts and recommendations are received through UHS/TJC/CMS and NRS.

5. A proactive component of the program includes annual selection of at least one high risk or error prone process for concentrated activity, ongoing measurement and periodic analysis. The selection may be based on information published by TJC Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality control, infection control, patient/family suggestions/expectations or process outcomes. The Primary initiative will be the discharge process. The discharge planning process will begin on admission and multidisciplinary staff compiles information to affect a safe discharge plan.

6. The following **Patient Safety Measures** will be the focus of 2016 Patient Safety activities:

- Seclusion and Restraint Use: Mechanical restraints were essentially eliminated in 2014. Continue to monitor and evaluate the use of seclusion and physical and chemical restraints. Use of Handle with Care program for interventions.
- Adverse Drug Events, including Medication Variances and ADRs. Define the ADR as any event that resulted in an unexpected or condition that required medical intervention.

- Healthcare Acquired Infections; report as necessary per the Sentinel event definition adopted in October 2013. Event related reports are submitted when required.
- Falls: Patient Falls Prevention Program. FMEA to continue in 2016.
- Elopements with analysis event related.
- Sentinel Event Reports (including any reportable patient event as they occur)
- Staff Patient Safety Culture Survey results annually with a plan for improvement.
- Discharge Checklist Compliance with annual review and revision as indicated.

7. Solicitation of input and participation from patients and families in improving patient safety will be accomplished by:

    a. Patient / family complaints or suggestions

    b. Comments from Patient Satisfaction surveys

8. Methods to assure ongoing education and training programs for maintenance and improvement of staff competence for safe patient care were implemented in 2013 and will be monitored again in 2016 as evidenced by:

    1. Orienting new staff members to WHH values and patient safety commitment and providing information on reporting mechanisms in the orientation training

    2. Providing ongoing education through education sessions, departmental meetings and/or other administrative communications, in-services and meetings

    3. Evaluating staff knowledge levels of patient safety principles through Heath stream program and contributions to patient safety in annual performance appraisals

9. Internal accountability for an effective patient safety program will be demonstrated via reporting to and oversight of the activities and results of the Patient Safety Council to the Medical Executive Committee and to the Governing Board.

10. A separate Environment of Care committee that addresses EOC safety considerations was instituted as a separate group in 2013 and will continue in 2016.

11. External Reporting: External reporting will be completed in accordance with all state, federal, and regulatory body rules, regulations and requirements.

12. An **annual evaluation** of the effectiveness of the Patient Safety Plan will be conducted and reported to the Medical Executive Committee and Governing Board and will include:

    a. The results of efforts to create and maintain a just and fair culture throughout the organization. *Completed in 2015 and to continue in 2016.*

b. The scope of occurrences including sentinel events, near misses and serious occurrences and the effectiveness of actions taken to prevent recurrence. *Completed in 2015 and continued in 2016*

c. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected. *Completed – ongoing.*

d. Performance results of the high-risk or error-prone processes selected for measurement and analysis.   Completed in *2015 and ongoing in 2016.*

e. The results of ~~how~~ input is solicited and participation from patients and families in improving patient safety is obtained and incorporated into the patient safety program.   *Completed in 2015 and ongoing in 2016.*

f. A description of the procedures used and examples of communication occurring with families about adverse events or unanticipated outcomes of care, if applicable during the reporting period~~.~~

g. A description of ongoing staff education and training programs that are maintaining and improving staff patient safety competence, participation in patient safety activities, and error reporting. Completed in 2015 and ongoing in 2016.

h. Recommendation for any indicated modification of the program organization or functions including incorporation of recognized advancements in patient safety practices.

12.   Evaluation or modification of the plan may be undertaken more often than annually if indicated. *Completed for 2015 ongoing in 2016*

13.   The facility's Disaster Response efforts will be incorporated into the overall patient safety efforts of the facility. The Disaster Preparedness approaches will be examined in light of patient safety considerations. The Patient Safety Officer will be charged with evaluating actual or potential patient safety issues arising during a disaster and reporting these to the PI Committee. *Completed for 2015 ongoing in 2016.*

SUBJECT: SAFETY MANAGEMENT PLAN	REFERENCE #HWN 134
	PAGE: 1
DEPARTMENT: HOSPITALWIDE	OF: 9
	EFFECTIVE: 10-1-12
APPROVED BY: Safety Committee	REVIEWED/REVISED: 12-18-12; 12-20-13; 12-16-14;12-15-15

MISSION:

Boulder City Hospital, Inc. (BCH) seeks to continually improve the quality of the care and service to our patients, residents, guests, and physicians. We promote effective and efficient utilization of available resources to ensure long-term financial viability. BCH seeks to earn the trust of the residents of Boulder City, neighboring communities and area visitors by meeting their health care, safety and related educational needs with compassion, integrity, sincerity, and without regard to one's ability to pay. The Safety Management Plan focuses on the management of the safety of patients, residents, staff and others through identification of safety risks and the planning and implementing of processes to minimize the likelihood of those environmental, care and service risks.

SCOPE:

The scope of the Safety Management Plan defines the processes which BCH utilizes to provide our patients, residents, personnel and visitors with a physical and care environment free of hazards and manages activities proactively through risk assessment to reduce the risk of injuries to patients, residents, staff and other individuals coming to the hospital. Due to the size and census of BCH, the organization has integrated the patient safety program and the safety management program and discusses topics of concern at the monthly Safety Committee meeting.

Representatives from the Safety Committee include members from clinical and nonclinical departments. In addition, the Safety Officer and Patient Safety Officer are appointed members of the Safety Committee and the Quality Improvement Committee. The Safety Officer is the facilitator for the Safety Committee. The Patient Safety Officer assists the Physician Chairman of the Quality Improvement Committee and the Medical Quality Improvement Committee.

OBJECTIVES:

The objective of BCH's Safety Management Plan is to control known and potential safety hazards to our patients, residents, personnel and visitors.

GOALS:

- The goals of BCH's Safety Management Plan include the following:

    - Maintain a safe environment and conditions for patients, residents, personnel and visitors

    - Reduce and control environmental hazards and risks of safety-related incidents by proactively evaluating systems in place and make the necessary changes through

the Safety Committee (which includes a Patient/Resident Safety agenda section every meeting), Quality Improvement Committee, Medical Quality Improvement Committee, Administration and Departmental participation

- Reduce and prevent accidents and injuries to patients, residents, staff and visitors

- Provide education to personnel on the elements of the Safety Management Program

- Inservice personnel on the use of and how to complete Quality Review Reports (QRR)

- Promote safe work practices and conditions

RESPONSIBILITY:

The Safety Officer, the Patient Safety Officer and Safety Committee are responsible for developing, implementing, monitoring and managing the Safety Management Program.

ELEMENTS OF PERFORMANCE:

APPOINTING OF QUALIFIED INDIVIDUAL:

- The Chief Executive Officer shall appoint a qualified individual as the Safety Officer to oversee, monitor and evaluate safety activities; to manage the safety management program that measures and analyzes safety levels, reduces risks and hazards; and to help identify problem areas for correction.

IDENTIFYING AN INDIVIDUAL TO INTERVENE WHENEVER CONDITIONS POSE AN IMMEDIATE THREAT:

- Administration has delegated to the Safety Committee through the Safety Officer and the Patient Safety Officer the authority to take action when hazardous conditions or potential hazardous conditions exist.

SAFETY ISSUES ARE EXAMINED BY APPROPRIATE REPRESENTATIVES:

- The Safety Committee shall include representation from administration and supervisory and line staff personnel from clinical and support services. All members of the Safety Committee are approved by the Safety Officer of the hospital.

- The Safety Committee shall develop a valid audit procedure and carry out periodic audits of organizational performance against the Safety Management Plan.

RISK ASSESSMENTS WHICH PROACTIVELY EVALUATE THE IMPACT OF BUILDINGS, GROUNDS, EQUIPMENT, OCCUPANTS AND INTERNAL PHYSICAL SYSTEMS ON PATIENT AND PUBLIC SAFETY:

- The Environmental Safety Inspection monthly audits are performed to evaluate the risks that may have an impact on patient/resident care, staff and visitors as it relates to the safety of the buildings, grounds, equipment, occupants, internal physical systems, the applicable regulations and the safe practices of hospital employees.

REPORTING AND INVESTIGATING INCIDENTS OF PROPERTY DAMAGE, OCCUPATIONAL ILLNESS AND PATIENT, RESIDENT, PERSONNEL AND VISITOR INJURY:

- The Safety Committee shall review summaries of property damage, occupational illness, accidents or injuries to patients, residents, visitors and/or personnel. Summary reports of incidents shall include evaluation of the incident, conclusions, recommendations and actions taken.

- All personnel will receive education on what constitutes an incident and completing a QRR. An incident consists of:

  - Property damage (hospital, patient, visitor or personnel including, damage, loss, etc.)

  - Occupational illness (needle sticks, back injury, etc.)

  - Unusual or dangerous occurrence (falls, equipment malfunctions, injuries or accidents, allegations of abuse, etc.)

- The Safety Committee will establish an incident reporting system:

  - The Risk Manager will investigate reported accidents and incidents. Serious accidents or an unusual frequency of accidents will be investigated by the Safety Officer or Patient Safety Officer and the Safety Committee. All QRRs will be reviewed and studied by the Risk Manager and the Patient Safety Officer. The Safety Officer will identify trends and make recommendations to the Safety Committee to prevent the reoccurrence of incidents.

- Incidents will be aggregated on a quarterly basis and reported to the Safety Committee and/or the Quality Improvement Committee depending upon the type of occurrence by the Patient Safety Officer. Incidents will be tracked and trended to determine if patterns exist. Once a pattern has been identified, actions will be developed to improve performance.

- See QRR Policy, Medication Error Policy, Reducing Medication Error Policy

IDENTIFIED RISKS:

- Any risks that are identified through proactive risk assessments, environmental tours, reporting mechanisms, etc., will be evaluated, selected and have procedures and controls put into place to reduce to the lowest possible point the adverse impact on the safety and health of patients, personnel and visitors of the hospital. For those cases, where appropriate and deemed necessary, the failure mode effects and analysis process will be undertaken.

- Risks identified may include patient safety issues and employee safety, i.e., medication errors, patient falls, wrong site, wrong side surgery; visitor falls or injury, employee injury.

SAFETY POLICIES AND PROCEDURES:

The Safety Committee will develop written policies and procedures to enhance safety within the hospital and its grounds. The Safety and Emergency Preparedness Manual contains hospital wide guidelines as well as Departmental specific guidelines to promote a coordinated effort during times of Emergency situations such as Utility outages, Internal and External Disasters, Pandemic events, etc. Policies will be reviewed annually per Critical Access guidelines. The ultimate responsibility for development and maintenance of current department specific safety policies shall lie with the department managers with the assistance of the Safety Officer or Patient Safety Officer, as appropriate.

HAZARD SURVEILLANCE INCLUDING RESPONSE TO PRODUCT RECALLS:

- An ongoing hazard surveillance program including response to product safety recalls shall be maintained and reported through the Safety Committee and/or Quality Improvement Committee. Hazard Surveillance Inspection Surveys will be conducted annually in each department or service by individuals with expertise in safety issues. All surveys will be evaluated to determine if trends or patterns are present. A report will be submitted to the

Safety Management

Safety Committee identifying deficiencies, recommendations, actions taken and resolutions of the deficiencies following each survey.

- All product safety alerts, hazard notices and recalls will be directed to the Manager of Central Supply or Pharmacy depending upon the subject of the recall. The Manager of Central Supply or Pharmacy will check the clinical equipment and drug inventory to screen for equipment or medication matches and will route the recall notices as indicated, making the appropriate contact with vendors, supplier, manufacturers, etc. In the event equipment must be removed from service, the equipment is replaced with a safe effective substitute as available. The Central Supply Department will impound equipment removed from use due to recall notices until it can be rendered safe.

- The Central Supply Manager will report to the Safety Committee on hazard notices and recalls affecting the hospital and the follow-up activities undertaken.

MAINTAINING AND SUPERVISING ALL GROUNDS AND EQUIPMENT:

- The Maintenance Department Manager is responsible for supervising the activities of the ground's maintenance crew. The ground's maintenance crew will maintain the property according to the expectations of the hospital. Monitoring of equipment and preventive maintenance and inspection procedures, as well as education and training of users to protect against failure or user error, is monitored and maintained by the Maintenance Department Manager.

- The Maintenance Department Manager or designee will conduct a visual surveillance of the hospital's grounds (including the helipad) on a daily basis while on duty. Surveillance activities will include, but not be limited to:

  - Snow and ice, when applicable

  - Hazards including:

    - Rocks

    - Scraps of wood

    - Cans

    - Bottles

Safety Management

- Sand

- Refuse

- Spills

- Pavement failures

- Abandoned vehicles

- Safety hazard reports will be received by the Safety Officer and will be tracked, investigated and repaired/corrected as needed.

PERFORMANCE STANDARDS:

- The Safety Committee will develop and establish performance measures and related outcomes, in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high-risk, high volume, problem-prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:

  - The measure can identify the events it was intended to identify.

  - The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable.

  - The measure has defined data elements and allowable values.

  - The measure can detect changes in performance over time.

  - The measure allows for comparison over time within the organization or between the organization and other entities.

  - The data intended for collection are available.

  - Results can be reported in a way that is useful to the organization and other interested parties such as regulatory agencies.

  - Patient Safety Goals as identified by the Joint Commission

Safety Management

- The Safety Committee on an ongoing basis monitors performance regarding actual or potential risk related to one (1) or more of the following:

  - Staff knowledge and skills

  - Level of staff participation

  - Monitoring and inspection activities

  - Emergency and incident reporting

  - Inspection, preventive maintenance and testing of safety equipment

- Other performance measures and outcomes will be established by the Safety Committee, based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Safety Committee.

- To identify opportunities for improvement, the Safety Committee will follow the organization's improvement methodology, the FOCUS PDSA model. The basic steps to this model will consistently be followed and include Find, Organize, Clarify, Understand, Select, Plan, Do, Study, Act to create positive change and evaluate the effectiveness of the change.

- Should the Safety Committee feel a team approach (other than the Safety Committee) is necessary for performance and process improvement to occur, the Safety Committee will follow the organization's quality improvement guidelines for improvement team member selection. Should team development be deemed necessary, primarily, team members will be selected on the basis of their knowledge of the subject identified for improvement, and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.

- Quality improvement monitoring and outcome activities will be presented to the Safety Committee and or the Quality Improvement Committee by the Safety Officer, Patient Safety Officer and various Department Managers at least on a quarterly basis, with a report of performance outcome forwarded to the Medical Executive Committee and Governing Body quarterly.

ORIENTATION PROGRAM THAT ADDRESSES GENERAL SAFETY PROCESSES, AREA-SPECIFIC SAFETY, SPECIFIC JOB RELATED HAZARDS AND NEW EMPLOYEE ORIENTATION AND CONTINUING EDUCATION:

- The Safety Committee will provide safety-related information through:

  - Orientation of new employees

  - Continuing education of all hospital employees

  - Safety information bulletin boards

  - Maintaining Safety Policies and Procedures and Material Safety Data Sheets

  - By recommending purchase of safety equipment and suggesting any necessary physical changes to improve safety conditions

  - Distribution of Safety and Quality effort results to staff

- The Safety Committee shall coordinate educational activities in order to effect improvements in the safety of patients, visitors and staff. All staff will receive general safety orientation upon hire and annually thereafter. The orientation shall include: general hospital safety, patient safety, fire safety, emergency evacuation of patients, body mechanics/ergonomics, emergency management, medical equipment management, utility systems management, security management, hazardous materials and waste management and infection control. It is the responsibility of the department manager to train employees on departmental specific safety procedures and job-related hazards. Educational programs shall be based on industry standards and literature review and are continually adapted to reflect organizational experience and the evaluation of effectiveness of training programs.

- A record of staff education will be maintained.

ANNUAL EVALUATION OF SAFETY MANAGEMENT PLAN'S OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS:

- The annual evaluation of the Safety Management Program will include a review of the scope according to the current regulatory standards to evaluate if the program meets the standards and the current risk assessment of the hospital. The overall performance of the program will be reviewed by evaluating the results of quality improvement outcomes.

- The performance and effectiveness of the Safety Management Program shall be reviewed by the Safety Committee, the Medical Executive Committee and the governing body.

- Changes in the plan will be incorporated into an updated Safety Management Plan by the Safety Committee.

Annual Evaluation
Carson Tahoe Continuing Care Hospital
Organizational Patient Safety Plan
January 2016

The Organizational Patient Safety Plan for 2015 will be reviewed at the Patient Safety Committee in January 2016. The plan will need to be found consistent with the requirements of Nevada Revised Statutes 439.880 to 439.890, which govern the Patient Safety Program (including the Patient Safety Plan, Patient Safety Officer and Patient Safety Committee).

Patient Safety Committee continues to provide a venue for organizational communication of patient safety issues and concerns, review of Sentinel Events, Root Cause Analysis and RCA action plans. This committee reviews and analyzes dashboards and data, utilizes data and information to make recommendations and develop action plans, as appropriate, to improve patient safety and outcomes throughout the organization.

Findings for 2015 include:

1) **Committee Membership, structure, function:**
   a. Membership meets the NRS requirements and includes the following: Patient Safety Officer; Physician; Nurse; Pharmacist; Executive Member, Infection Control Officer.
   b. Additional non-required membership includes the following: Physical Therapist and Nurse Manager were added in 2015.
   c. The conceptual model for the Quality Reporting Structure that was revised in June, 2015, continues to be an effective model. Committees such as EOC, Infection Control, Ethics, Compliance Oversight and others can bring appropriate patient safety issues to the Patient Safety Committee for discussion, recommendations, and actions.
   d. Patient Safety Committee will continue reporting to the CTCCH Board, the System Quality Patient Safety Committee, and the System Board of Directors. There will continue to be a dotted-line reporting to the Quality Summit Committee and Medical Executive Committee on an as needed basis.

2) **Dashboard trending**
   The dashboard is a dynamic document, providing a "snapshot" of trended data over time including but not limited to the following:

   1. Quality/Patient Safety Measures and indicators including:
      a. Medication Events
         i. KBMA Compliance
      b. Falls
      c. Infection Control measures
         i. CAUTI
         ii. CLABSI
         iii. Handwashing Compliance
         iv. VAP
      d. Pressure Ulcers

2. Goals/Benchmarks for measures/indicators
3. Tracking survey findings and compliance with action plans

Note:
1. National Patient Safety Goals will no longer be applicable due to the pursuit of Center of Improvement in Healthcare Quality (CIHQ) as the hospital's accrediting organization.

3) Ad hoc/sub committees or RCIT
Sub committees and RCIT teams are formed as needed in response to data or specific patient safety concerns that are brought to the Patient Safety Committee.

Falls: Data will be reviewed by the Continuing Care Hospital Patient Safety Committee monthly and data will be reported up through the Committee's reporting structure.

General falls numbers for Inpatients only
2013:   25
2014:   12
2015:   21

Future reporting will include the following data breakdown for falls:

o   Continuing Care Hospital Inpatient Department meeting or better than benchmark
o   Overall injury from falls
o   Major injury from falls
o   Contributing factor reported as bathroom or toileting

4) Accreditation Organization:
Carson Tahoe Continuing Care Hospital has applied for CIHQ accreditation. The Mock Survey is scheduled for March 16 & 17, 2016 with possible accreditation survey in the second quarter of FY16.

5) Sentinel Event Reporting
Since Nevada adopted the National Quality Forum 2011 Guidelines, effective 2014, a substantial reduction in reportable, sentinel events has resulted.

Sentinel Events Reported
2015:   0

Future data for sentinel events will include intense reviews conducted on near misses, events with potential for patient harm, mild or moderately adverse outcomes, and variances from practices, policies or standard procedures.

Recommendations for 2016:

1) **Committee membership, structure and function:**
   Based upon review of the NRS 439 requirements regarding the Patient Safety Officer, plan, committee, duties and responsibilities, the Continuing Care Hospital will be modifying the Committee membership to include the following:
   a. Certified Nursing Assistant
   b. Wound Care RN
   c. Staff RN
   d. Physical Therapist
   e. Respiratory Therapist

2) **Dashboard trending report:**
   Recommend the annual review and evaluation of the Dashboard in January 2016
   a. Recommend removing any indicators that are determined to be stable or hardwired.
   b. Recommend continuing quarterly monitoring for indicators that are stable, but required due to regulatory requirements.
   c. Recommend continuing with the 2015 Benchmarks as identified by the CTH Quality Department.
   d. With the implementation of KBMA, medication scanning system, recommend monitoring compliance with usage and other indicators as deemed appropriate to determine impact of system on patient safety.
   e. Recommend including Code Blue tracking
   f. Recommend including tracking compliance to meet new regulatory reporting for skin assessments.

3) **Ad hoc/sub committees or RCIT:**
   Recommend continuing to closely monitor falls and continued report to Quality Summit.

4) **Sentinel Event Reporting**
   Recommend continued monitoring for adverse and sentinel events, continue reporting RCA investigation and action plans as required. Continue reporting intense reviews, action plans and making recommendations for improvements to patient care.

5) **Patient Safety Plan**
   Format changes to be consistent with other Quality Department plans. No other changes recommended for 2016.

CARSON TAHOE
Regional Healthcare

PATIENT SAFETY PLAN

2015

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*

INTRODUCTION

Carson Tahoe Regional Healthcare's Core Values are **"Putting Patients First and Treating Everyone with Dignity and Respect"**. With the support of the Board of Hospital Trustees and Organization Leadership, the Patient Safety Program and Patient Safety Plan are committed o a "Culture of Safety" consistent with our Mission and Core Values.

PURPOSE

The Patient Safety Plan provides a planned, systematic, coordinated approach for continually improving the health and safety of patients who are treated at the medical facility, by reducing patient harm and maintaining a safety culture.

The Patient Safety Plan includes:
- Establishment of a patient safety committee:
  - Membership to include:
    - Patient Safety Officer
    - Infection Control Officer
    - At least 3 providers of health care who treat patient at the medical facility, including one medical, nursing and pharmaceutical staff
    - One member of the executive or governing body
  - Meetings required at least once per month
- An Infection Control Program to prevent and control infections within the medical facility (this is a document separate from the Patient Safety Plan that meets the requirements for NRS 439.865)
- Adoption of Patient Safety checklists and patient safety policies as required by NRS. 439.877
  - Adoption of patient safety checklists and policies
  - Annual review and revision of checklists and policies
    - 2014 Checklist Inventory *Attachment A*
  - Annual Report to Legislative Committee on Health Care
- Integration of all patient safety activities both ongoing and developing
- Ongoing orientation, education and training to emphasize specific job related aspects of patient safety to maintain and improve staff awareness
- Encourage internal reporting of medical / healthcare incidents and events, effectively respond to actual occurrences, manage occurrences and events with a non-punitive approach, and focus on processes and systems to minimize individual blame and retribution
- Periodic survey of the staff regarding willingness to report, actions taken and outcomes of occurrences and events
- Internal reporting of findings, actions taken and resolution; organizational learning and communication of occurrence and event information
- Consideration of patient safety priorities when designing and redesigning of relevant processes, functions and services
- Involvement and education of patients and their families about their role in facilitating safe delivery of care, identifying potential risks and suggesting improvement to patient safety

SCOPE OF ACTIVITIES

The Patient Safety Committee integrates all components of safety into the organization wide safety program by collaboration among ~~with~~ the following, including but not limited to Quality, Environmental Safety, Infection Control, Patient Care areas, ~~and~~ Risk Management, Compliance and Ethics.

Patient Safety Committee activities include:

- Receive and review investigative reports from the Patient Safety Officer regarding Sentinel events alleged to have occurred, and actions taken to ensure the safety of patients resulting from Sentinel Events reported to State of Nevada Pursuant to NRS Chapter 439
- Make recommendation to the executive or governing body to reduce 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
  - o The number of sentinel events that occurred the previous quarter
  - o The number and severity of infections that occurred the previous quarter
- Review and evaluate the quality measures carried out by the medical facility to improve the safety of the patients who receive treatment.
- Review and evaluate the quality measures carried out by the medical facility to prevent infections
- Monitor patient and environmental safety issues identified throughout the organization.
- Promote the use of internal and external knowledge and experience to prevent patient harm, events and occurrences, and to maintain and improve patient safety and prevent unsafe occurrences.
- Review aggregated or trended data: No harm events, Mild or moderate adverse outcomes, Near miss, Medication events, Adverse drug reactions, Transfusion reactions, Hazardous conditions, Present on admission, ~~or~~ Hospital acquired conditions, or Online incident reports, utilizing a proactive approach to recognize and acknowledge medical / healthcare events and risks to patient safety, to make recommendations and initiate actions to reduce those events and risks
- Prioritize and recommend Patient Safety activities, as appropriate.
  - o Types of Environmental safety data/activities that may be reviewed, aggregated or trended may include: Security, Employee safety / job related injuries, Emergency preparedness, Lab or radiation safety, Utilities management, Bio med or Fire drills inspections

PATIENT SAFETY OFFICER

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

- Serving on the Patient Safety Committee
- Supervising sentinel event reporting to the State
- Conducting mandatory investigations; developing and implementing action plans
- Ensuring notification as appropriate within the medical facility

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

Carson Tahoe Regional Medical Center		
2015 Checklist Inventory		
Checklist title	Checklist Category	DEPT
Discharge Checklist for nursing	Discharge	BHS
Discharge Checklist for patient	Discharge	BHS
Discharge Planning Checklist	Discharge	BHS
Discharge Checklist	Discharge	Electronic Health Record
Fire Drill Participation	Environment	Housewide
Fire Report	Environment	Security
Fire Watch Form	Environment	Security
Life (Fire) Safety Inspection / Business Occupancy	Environment	Security
Life (Fire) Safety Inspection /Healthcare Occupancy	Environment	Security
Patient Room Housekeeping Checklist by area /by shift		
Form 100 Lead/Admin	Environment	Housekeeping
Form 101 Med Onc B / Rehab	Environment	Housekeeping
Form 102 Med Onc A & Pharmacy	Environment	Housekeeping
Form 103 Tele & Therapy	Environment	Housekeeping
Form 104 OB / Peds	Environment	Housekeeping
Form 105 Surg Ortho	Environment	Housekeeping
Form 106 ICU/CVU	Environment	Housekeeping
Form 107 ER /OBS / Fast track Days	Environment	Housekeeping
Form 108 OR days	Environment	Housekeeping
Form 109 Cath Lab /Outpatient Days	Environment	Housekeeping
Form 110 Areas to "police"	Environment	Housekeeping
Form 111 Waste Management Days	Environment	Housekeeping
Form 112 BHS Check Sheet	Environment	Housekeeping
Form 113 Senior Pathways & BHS Outpatient	Environment	Housekeeping
Form 114 Projects / Floor Care	Environment	Housekeeping
Form 200 Lead	Environment	Housekeeping
Form 201 Med Onc A and B Swing	Environment	Housekeeping
Form 202 Tele / OB Swing	Environment	Housekeeping
Form 203 Surg Ortho Swing	Environment	Housekeeping
Form 204 ICU / CVU Swing	Environment	Housekeeping
Form 205 ER / OBS Fast track Swing	Environment	Housekeeping
Form 206 OR Swing	Environment	Housekeeping
Form 207 X-ray / Cath / Outpatient Swing	Environment	Housekeeping

Carson Tahoe Regional Medical Center 2015 Checklist Inventory		
Form 208 Waste Management Swing	Environment	Housekeeping
Form 209 SMC First floor	Environment	Housekeeping
Form 210 Cancer / Merriner	Environment	Housekeeping
Form 211 Minden check list	Environment	Housekeeping
Form 212 Mica Surgery / Pain Clinic	Environment	Housekeeping
Form 213 Projects / Floor Care	Environment	Housekeeping
Form 214 Projects / Floor Care	Environment	Housekeeping
Form 215 Projects / Floor Care	Environment	Housekeeping
Form 216 Lab / Offices Swing	Environment	Housekeeping
Form 301 ER / OBS / Fast track Grave	Environment	Housekeeping
Form 302 OR Grave	Environment	Housekeeping
Form 303 Projects / floor Care	Environment	Housekeeping
Quality Assurance Checklist	Environment	Housekeeping
Pediatric Unit Department Checklist	Environment	PEDS
CRASH CARTS		
Adult Crash Cart Check List	Other Safety	Housewide
New born Crash Cart Checklist	Other Safety	Housewide
OB hemorrhage Cart Checklist	Other Safety	Women's / Children
Pediatric Crash Cart Checklist	Other Safety	Women's / Children
OB Recovery Room Red Cart	Other Safety	Women's / Children
Obstetrics OR checklist	Other Safety	Women's / Children
3M Steam Flash Sterilization Log	Other Safety	Housewide
AED Checklist	Other Safety	Housewide
Breast Milk Refrigerator Temperature Log	Other Safety	Women's / Children
Refrigerator / Freezer Temperature Record	Other Safety	Housewide
Blanket Warmer Temp Logs		Housewide
Cidex Log	Other Safety	Housewide
List & Process Monitor Documentation System	Other Safety	GBI
Nevada State Immunization Program Temperature Log	Other Safety	Women's / Children
Nursery Blanket Warmer Temperature Log	Other Safety	Women's / Children
OB Recovery Room Red Cart	Other Safety	Women's / Children
Obstetrics OR Checklist	Other Safety	Women's / Children
OR Blanket Warmer Temperature Log	Other Safety	Housewide
Ticket to Ride	Other Safety	Housewide
Ventilator Calibration Checklist	Other Safety	Respiratory
Admission Checklist	Other Safety	BHS
BHS Unit Safety Rounds Worksheet	Other Safety	Housewide

Carson Tahoe Regional Medical Center 2015 Checklist Inventory		
Central Line Associated Blood Stream infection and CAUTI surveillance	Other Safety	Housewide
Emergency Equipment checklist	Other Safety	ICU
Urgent Hearth Chart Daily checklist	Other Safety	ICU
Hand Hygiene	Other Safety	Infection Control
Infection control Monitoring during construction	Other Safety	Infection Control
Patient Observation Checklist	Other Safety	Security
AIC Chemo Waste	Other Safety	AIC
AMA Intervention checklist	Other Safety	BHS
Antibiotic Support team Review Form	Other Safety	Infection Control
Central Line Insertion	Other Safety	Infection Control
Charge Nurse checklist	Other Safety	BHS
Chemotherapy Administration check list	Other Safety	Med Onc
Chart Deficiency Check list	Treatment	Surgical areas
Hand Off Communication sheet Pre-op/OR/PACU	Treatment	Surgical areas
HSM Intraop Surgical checklist "Before Induction of Anesthesia "	Treatment	Surgical areas
HSM Intraop Surgical Checklist "Before Patient Leaves Operating Room"	Treatment	Surgical areas
HSM Intraop Surgical Checklist "Before Skin Incision"	Treatment	Surgical areas
HSM Pre-op checklist	Treatment	Surgical areas
Magnetic Resonance Imaging History & Assessment	Treatment	Medical Imaging
Medical Imaging Invasive Procedure Checklist	Treatment	Medical Imaging
Non Ionic and/or Ionic Contrast Consent Form	Treatment	Medical Imaging
Perioperative Nursing Care Plan	Treatment	Surgical areas
Pre Cath / Vascular Lab Checklist	Treatment	Cath Lab
Pre-Op Education	Treatment	Mica Surgery
PsychoSocial Treatment Plan tracking form	Treatment	BHS
Sharp Contraband Tracking Form	Treatment	BHS
Surgical Checklist	Treatment	Surgical areas
Universal Protocol Checklist	Treatment	Surgical areas
Universal Protocol Checklist for Injection Procedures	Treatment	Surgical areas
Foley Catheter Tracking	Treatment	Infection control

Attachment B

CTRS Board of Directors/CTPH Board of Trustees
CTHS Quality/Patient Safety Committee

Quality Management Committee

Medical Executive Committee

CME Committee

Utilization Management Committee (new)

Pharmacy and Blood Utilization Committee

Med Staff Quality & Professional Practice Evaluation

Medicine Department

Credentials Committee

OB / Peds Section

ED Section

Radiology Section

Surgery Department

Anesthesia Section

Infection Control Committee

Patient Throughput Committee to include (new) Lab/Imaging / Pharm/ Admit/IT Efficiency Reporting

IT Order Set Review Committee WAC

Quality Summit

ACLS/Code Blue Committee

Quality Work Groups

Patient Complaint Committee

Ethics Committee

Patient Safety Committee

Compliance Oversight Committee

EOC/Safety Committee

Draft #3 12.17.12 Quality

CARSON VALLEY MEDICAL CENTER	Section/number	Revision Date:
Department: **Quality**	QA 2.004	Revision Date:
Assurance and Risk Management		6/22/09 7/17/09 3/4/11 7/12/11 12/9/11 5/21/12, 2/27/15
	New Date:	Reviewed Date: 8/27/10
Title: Patient Safety Program	8/13/08	12 pages

PURPOSE:

The purpose of the organizational Patient Safety Program at Carson Valley Medical Center is to improve patient safety and reduce risk to patients through an environment that encourages:

- A Patient Centered approach to care

- Integration of safety priorities into all relevant organization processes, functions and services

- Recognition and acknowledgment of risks to patient safety and medical/health care errors

- The initiation of actions to reduce these risks

- The internal reporting of what has been found and the actions taken

- A focus on processes and systems, and the reduction of process and system failures.

- Minimization of individual blame or retribution for involvement in a medical/health care error

- Organizational learning about medical/health care errors

- Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations

The Patient Safety Program provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

As we work toward Patient Centered Care, and therefore the maintenance and improvement of patient safety, it is a coordinated and collaborative effort. The approach to optimal patient safety involves all departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Carson

Valley Medical Center. The Patient Safety Program is developed by an interdisciplinary Hospitalist/Patient Safety Committee, the Environment of Care Committee, and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PROGRAM:

Scope of Activities:

The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety. Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Patient Safety Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:

- No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.

- Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.

- Any Medication Error resulting in an adverse event

- Any Adverse Drug Reaction

- Any Transfusion Reaction

- Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

Sentinel Event –NRS 439.830
"An unexpected occurrence involving facility acquired infection, death or serious physical or psychological injury or the risk thereof, including without limitation, any process variation from which a recurrence would carry a significant chance of a serious adverse event. The term includes loss of limb or function."

◆ The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

◆ The event is one (1) of the following (even if the outcome was not death or major permanent loss of function):

Reporting Requirements NRS 439.835 Appendix A:
1. Surgical or Invasive Procedure Events
   A. Surgery or other invasive procedure performed on the wrong site
   B. Surgery or other invasive procedure performed on the wrong patient
   C. Wrong surgical or other invasive procedure performed on a patient
   D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
   E. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient
2. Product or Device Events
   A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
   B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
   C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
3. Patient Protection Events
   A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
   B. Patient death or serious injury associated with patient elopement (disappearance)
   C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting
4. Care Management Events
   A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
   B. Patient death or serious injury associated with unsafe administration of blood products
   C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
   D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
   E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
   F. Any Stage 3, Stage 4, or unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
      G. Artificial insemination with the wrong donor sperm or wrong egg

H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. Environmental Events
A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

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

7. Potential Criminal Events
A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
B. Abduction of a patient/resident of any age
C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

- Near Miss - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:

- Ethics, Rights and Responsibilities

- Provision of Care, Treatment and Services

- Medication Management

- Surveillance, Prevention and Control of Infection

- Improving Organization Performance

- Leadership

- Management of the Environment of Care

- Management of Human Resources

- Management of Information

Methodology:

The Patient Safety Committee is responsible for the oversight of the Patient Safety Program. The Risk Manager will have administrative responsibility for the program.

NRS 439.875 A Patient Safety Committee established pursuant to subsection 1 must be composed of:

(1) The Infection Control Officer of the medical facility.

(2) The patient safety officer of the medical facility.

(3) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.

(4) One member of the executive or governing body of the medical facility.

(b) The Patient Safety Committee shall meet at least once each month.

The Patient Safety Committee shall:

(a) Receive reports from the patient safety officer pursuant to **NRS 439.870**.

(b) Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.

(c) Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.

(d) Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections at the medical facility.

(e) Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at the medical facility.

(f) At least once each calendar quarter, report to the executive or governing body of the medical facility regarding:

1) The number of sentinel events that occurred at the medical facility during the preceding calendar quarter; and
2) The number and severity of infections that occurred at the medical facility during the preceding calendar quarter
3) Any recommendations to reduce the number and severity of sentinel events that occur at the medical facility.

(g) Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

The Patient Safety Officer duties include:

(a) Serve on the patient safety committee.

(b) Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing the duties required pursuant to **NRS 439.835**.

(c) Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility.

(d) Report to the patient safety committee regarding any action taken in accordance with paragraph (c).

All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Risk Manager, who will aggregate occurrence information and present a report to the Patient Safety Committee on a monthly basis, and the Environment of Care Committee on a quarterly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Patient Safety Committee will analyze the report information and determine further patient safety activities as appropriate. The recommendations will be sent to the Environment of Care Committee.

- Through review of internal data reports and reports from external sources (including, but not limited to the Joint Commission sentinel event report information, Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the Risk Management PI report, the Environment of Care Committee will review Patient Safety occurrences.

- 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

- Document the process improvement on the CQI form and send to the QA department

<u>Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organization wide program.</u>

Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:

Perform necessary healthcare interventions to protect and support the patient's clinical condition.

- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.

- Contact the patient's family/caregivers to report the incident. Contact the attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary. Document that this has been done in the medical record.

- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record <u>as appropriate</u> to organizational policy and procedure.

- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.

- Submit the occurrence report to the Risk Management Department per organizational policy.

Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Risk Management Department per organizational policy.

Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:

- <u>No Harm Failures or Errors</u> - (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Risk Management Department and notify their immediate supervisor.

- <u>Mild-Moderate Adverse Outcome Failures or Errors</u> (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Risk Management Department per organizational policy.

  - ♦ <u>Medication Errors</u> - the staff member identifying a medication error (no harm and mild-moderate harm) will complete an occurrence report.

- **Adverse Drug Reaction** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report, submitting the report to the Risk Management Department per organizational policy. Staff will also notify the Pharmacy Department.

- **Transfusion Reaction** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the Suspected Transfusion Reaction Nursing Worksheet Policy and Procedure BB-35.

- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Risk Management Department per organizational policy.

- **Sentinel Event** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. The staff will also notify the patient's family/caregiver to notify them of the incident and will document all notifications and interventions in the medical record. Staff will then follow the organizational Sentinel Event Policy and Procedure.

- **Near Miss** - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an occurrence report and submit the report to the Risk Management Department.

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

- ■ Further remedial action activities necessary for identified occurrences

- ■ Proactive occurrence reduction activities

- ■ Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

- An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences. ***See Non-punitive reporting of incidents and sentinel events policy #2.025***

- All personnel are <u>required</u> 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 <u>assist</u> rather than punish staff members, with the Patient Safety Committee and the Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.

  - ■ <u>Sentinel Events</u> – Quality Assurance and Risk Management encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Human Resources Department and/or his or her department supervisor.

- The Patient Safety Program includes implementation of the recommendations set forth by the Joint Commission, or identified alternative recommendations defined by this institution, to achieve compliance with the Joint Commission established National Patient Safety Goals. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified National Patient Safety Goals.

- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. *See Managing the Disclosure of Unanticipated Outcomes policy # 2.049.*

- Peer-to-peer observation will be used ensure compliance with patient safety   checklists and will offer opportunities for corrective feedback. This approach is a learning opportunity not intended for disciplinary purposes. *See Active Surveillance of Patient Safety Checklist Use policy # 2.030.*

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

  Patient safety reports from the Patient Safety Committee will be submitted to the organizational Environment of Care Committee.
- A quarterly patient safety report will be forwarded to the Governing Body on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.

AB 280: CVMC has adopted the use of the following Patient Safety Checklists;
A. Patient Safety checklists included in the medical record;
1. Non-OR Invasive Procedure checklist,
2. Central Line Procedural checklist,
3. Inter-facility Transfer checklist,
4. Neurological checklist,
5. Sitter Observation checklist,
6. Initial ventilator setting checklist,
7. Medication Reconciliation form,
8. Discharge Instruction Sheet,
9. Surgical checklist

B. Patient safety checklists **Not** included in the medical record include;
1. Hand off tool,
2. Hand Hygiene Observation,
3. Multidisciplinary rounding checklist
4. Quality Assurance device tracking
5. Environment of Care/Infection Control Checklist
6. Infection Control Weekly Construction Site Observation checklist
7. CDC Environmental Checklist for Monitoring Terminal Cleaning
8. Ventilator bundle checklist,
10. Surgical site verification checklist

Please refer to the Infection Control Program policy # 101.12 for more information

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Original Effective Date:	01/2012	Revised Date:	01/2016
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Approved By:	CEO/Managing Director, COO, CNO	Page(s):	Page 1 of 8

I.   PURPOSE:

The purpose of the Patient Safety Program/Plan is to create, maintain and sustain a safety oriented culture for Centennial Hills Hospital Medical Center (CHHMC). The safety-oriented culture is to provide a clinically safe environment for our patients, visitors, physicians, staff and volunteers. The Patient Safety Plan, developed by the interdisciplinary Patient Safety Council and approved by the hospital administration and the Governing Body, outlines the components of the organizational Patient Safety Program. The Governing Board further delegates that this committee will review all formal patient grievances on a quarterly basis and ensure that resolution is achieved and provide direction for activities to decrease and/or prevent reoccurrences of those issues.

II.   PRACTICE:

This safety-oriented culture promotes the identification and reporting of actual events and potential risks to patient safety. CHHMC leaders support behaviors and actions that:

Focus on processes and systems failure when events occur.
Minimize individual blame or retribution.
Prevent medical errors or events.
Conduct proactive risk reduction assessments of high-risk processes based on Sentinel Events Alerts published by The Joint Commission or any accrediting agency.
Communicate events through internal reporting.
Support the sharing and learning of information to affect change in behavior and processes.

Goals for Patient Safety Plan and Patient Safety Council:

Create and maintain a culture of safety and quality throughout the hospital.
Implement interdisciplinary education/training of patient safety standards, program/plan and individual accountability.
Improve patient safety though on-going proactive assessment and use of tools such as root cause analysis, intense analysis, and failure mode and effects analysis (FMEA).
Implement immediate response processes to sentinel events.
Implement response and processes to unanticipated/unexpected events.
Assess the resource allocations for patient safety
Analyze safety event data to achieve reduction in events/errors or injury.
Establish a reporting system that promotes and supports non-punitive actions.

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Scope:

This plan is intended to provide a systematic, coordinated and continuous approach to patient safety. Activities and functions of the Patient Safety Program/Plan are integrated within all functions and activities of patient care and delivery of services. The activities listed below are considered the core activities of this plan but are not limited to these activities:

Establish visible, consistent focus on patient safety and risk reduction of events
Assess medical/health care events ranging from potential events to sentinel events.
Assess prevalence and severity of infections that occurred at the hospital.
Review and evaluate the quality of measures carried out by the hospital to prevent and control infections.
Conduct proactive risk reduction assessments of high-risk processes based on Sentinel Event Alerts published by The Joint Commission or any accrediting agency.
Coordinate and direct activities addressing published Sentinel Event Alerts.
Train and educate members of healthcare team for patient safety.
Integrate department and staff participation in the program.
Assists with Root Cause Analysis for Sentinel Events, or unexpected events
Conduct proactive risk assessments using failure mode and effects analysis.
Establish a reporting system that promotes a non-punitive system.
Focus opportunities on processes and systems and not the individual performance.
Establish patient safety priorities in the design and redesign of services, processes and systems.
Assess, measure, and analyze safety event data to identify trends, patterns or opportunities for improvement.
Prioritize patient safety opportunities according to criteria.
Review and revise patient safety checklists, policies, and processes and adopt recommended additions for hospital use.

Structure:

Management of the Plan:
This plan is developed, implemented, coordinated, and directed by the Director of Risk Management, Patient Safety Officer, and the Patient Safety Council. The Patient Safety Council is an interdisciplinary committee comprised of medical staff leaders, administration, risk management, quality management, Infection Control Officer, pharmacy, and nursing. Ad Hoc support and clinical departments are asked to participate as necessary. The Patient Safety Council functions in collaboration with other hospital and medical staff committees,

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such as but not limited to: Environment of Care Committee, Medication Safety Committee, Infection Control Committee, and Medical Executive Committee. The committee will meet monthly unless prior approval is obtained to cancel by the UHS Area Risk Manager.

The Patient Safety Council reports directly to the Medical Executive Committee and to the Governing Board.

III.   PROCEDURE:

Chair of the Patient Safety Council will be the Chief Executive Officer.

Implements, directs all aspects of the Patient Safety Program/Plan.
Directs development of processes for:
Sentinel Event Review
Root Cause Analysis
Identification of opportunities related to root cause analysis
Implementation of improvements
Measurement of improvements
Sentinel Event Alert Review Processes
Assessment of current practice
Implementation of improvements
Conduct proactive risk assessment and failure mode and effects analysis.
Facilitate integration with Risk Management activities
Facilitate education on patient safety
Facilitate measurement for safety events, and technology to support program
Facilitate communication of patient safety findings, opportunities, and improvements throughout the hospital.
Serve as Internal Expert on Patient Safety standards for the organization.

Patient Safety Officer Authority:

Patient Safety Officer has a hospital wide oversight, with the authority to review, assess, analyze and conduct root cause analysis or failure mode and effects analysis of any event, process or systems that relate to potential risk to patient safety regardless of department or management structure.

Integration and Coordination:

The Patient Safety Program/Plan functions in collaboration and integration with all departments, policies, procedures, and established plans. This integration is accomplished through interdisciplinary membership on committees, such as, but not limited to:

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Medication Safety Committee
Infection Control Committee
Environment of Care-Safety Committee.

Communication with Patients:

All patients will receive education related to patient safety, and their environment on point of entry to service/diagnostic area or treatment area. The education will be specific to the area and the patient needs.

In accordance with patient rights, patients and when appropriate family/significant other will be informed about hospital acquired infections, outcome of care, including unanticipated outcomes or when outcomes differ from expected. The attending physician or designee is responsible for informing the patient and/or family. Additional interdisciplinary members may be included in this communication as appropriate.

Staff Education:

Staff will receive education and training during their orientation and on an on-going basis regarding job specific aspects of patient safety, including the need to report medical/health events. The education of the staff will be interdisciplinary teamwork as the delivery of patient care is interdisciplinary.

Patient Safety Improvement Activities:

Definition of Terms:

Patient safety event: An event, incident, or condition that could have resulted or did result in harm to a patient.

Adverse event: A patient safety event that resulted in harm to a patient.

Sentinel event: A subcategory of Adverse events, a Sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and results in death, permanent harm, or severe temporary harm.

No-harm event: A patient safety event that reached the patient but does not cause harm.

Close call (near miss or good catch): A patient safety event that did not reach the patient.

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Hazardous (or unsafe) condition(s): A circumstance (other than the patient's own disease process of condition) that increases the probability of an adverse event.

Patient Safety Prioritization of Improvement Activities

Improvement activities are prioritized according to set criteria, that includes: compliance related to accrediting standards or error prone or high risk processes, mission/vision/values, strategic/operational goals and cost/benefit analysis. Priority of activities will be discussed and/or reviewed with the Patient Safety Council. **Routine Safety-Related Data Collection and Analysis Incident Report**

All departments within the organization (clinical and support) are responsible to report any patient safety events, and potential events by the completion of incident report. This report is then routed to Risk Management. Risk Management screens reports for potential sentinel events or unexpected events/outcomes. Risk Management will communicate on an on-going basis with the Patient Safety Council regarding clinical events, and/or trends such as patient falls, medication errors, treatment error or unexpected outcomes.

Risk Management will provide data, data analysis of events to the Patient Safety Council on a systematic basis. The Patient Safety Council will use data to:
- Monitor conditions and performance within the hospital
- Identify risks for acquiring and transmitting infections in accordance with the Infection Control Plan.
- Identify risks regarding medication management.

Data will be:
- Presented in a clear manner
- Shared with the appropriate groups throughout the organization
- Used to identify opportunities for improvement and actions to be taken clearly articulated

Facility Safety Surveillance

These activities will be accomplished in accordance with the Environment of Care Plans, but will be integrated as appropriate to patient safety.

Staff Perception of and Suggestions for Improving Patient Safety

An survey of staff, including physicians, all disciplines and support staff, will be conducted to seek suggestions for improving patient safety. Staff willingness to report errors will be included in this survey. This data will be analyzed and opportunities for improvement will be prioritized and implemented through the Patient Safety Council.

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Patient/Family Perception of and Suggestions for Improving Patient Safety

The hospital wide patient satisfaction survey will include questions on patient perception of safety and request for suggestions in safety. This data will be reported quarterly to the Performance Improvement Committee. Opportunities and improvements will be implemented as indicated and appropriate.

Identification, Reporting, and Management of Sentinel Event or High Risk/Unusual Incidents:

Upon identification of a medical/health care event, the patient care provider will:
- Perform necessary health care interventions to protect and support the clinical condition.
- Contact the attending physician and consulting physicians as appropriate, to report error
- Implement physician orders as appropriate
- Preserve information related to the event/error
- Document the facts of the event/error in the medical record according to policy/procedure
- Report event error to immediate supervisor
- Immediate supervisor/manager will contact Patient Safety Officer and Risk Management as appropriate.
- Submit an incident report to Risk Management according to policy/procedure
- The Risk Director will review all events/errors that meet the definition of Sentinel Event, Near Miss, Significant Medication Error or unexpected outcomes as appropriate.
- Staff members involved in a sentinel event, near miss, or unexpected outcome will receive support regarding staff member's professional and emotional reconciliation of event/error. Support may be through Employee Assistance Program.
- The Director of Risk Management will determine follow up actions such as, but not limited to root cause analysis and or referral to Peer Review.
- Sentinel Event, Near Miss, Significant Medication Errors, unexpected outcomes will be reported to the Patient Safety Council, Performance Improvement Committee and Governing Board, as appropriate.
- Risk Management will report any Sentinel Event to State of Nevada Health Division.

Proactive Risk Reduction Activities:

The proactive assessment or FMEA will include, but not limited to:
- Assess the intended and actual implementation of the process to identify the steps for possible and actual variation using the failure mode and effects analysis.

Policy Title:	Patient Safety Plan 2016		
Hospital:	Centennial Hills Hospital Medical Center		
Location:	Housewide, Provision of Care, Treatment and Services (PC)		
Policy Number:	N/S	Reviewed Date:	02/2012, 02/2014
Original Effective Date:	01/2012	Revised Date:	01/2016
Issued By:	Risk Management	Current Effective Date:	01/2016
Approved By:	CEO/Managing Director, COO, CNO	Page(s):	Page 7 of 8

- For each failure mode, identify the possible effects of the undesirable variation on patients and how serious the possible effect could be.
- For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to the effect may occur.
- Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or protect patient from the effects of that undesirable variation.
- Test and implement the redesigned processes.
- Identify and implement measures of the effectiveness of the redesigned process
- Implement a strategy for maintaining the effectiveness of the redesigned processes over time.
- Proactive assessment and action will be reported to the Patient Safety Council and Governing Board as appropriate.
- Communication to leadership, hospital, medical staff committee and departments will be facilitated by Patient Safety Officer.

Patient Safety Checklists

Effective July 1, 2011 patients safety checklists will be utilized where appropriate as the committee determines necessary and by state statute.
Annually, the Patient Safety Committee will review and revise patient safety checklists, policies, and processes and adopt recommended additions for hospital use.

Program/Plan Evaluation:

An annual evaluation will be conducted and reported to Patient Safety Committee, Performance Improvement Committee and Governing Board. The evaluation will include, but is not limited to the following:

> National Patient Safety Indicators/Measures
> Staff Education Needs Assessment
> Proactive Risk Assessments
> Incident/event reports
> Sentinel Events
> Root Cause Analysis
> Failure Mode and Effects Analysis
> Patient Satisfaction Surveys
> Staff Survey

Based on the analysis, program/plan and goal revisions will be recommended to the Patient Safety and Governing Board

Policy Title:	Patient Safety Plan 2016		
Hospital:	Centennial Hills Hospital Medical Center		
Location:	Housewide, Provision of Care, Treatment and Services (PC)		
Policy Number:	N/S	Reviewed Date:	02/2012, 02/2014
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IV.   REFERENCES:

NRS 439.877 Patient Safety Checklists and Patient Safety Policies
NRS 439.865 Patient Safety Plan
NRS 439.870 Patient Safety Officer
NRS 439.875 Patient Safety Committee

CHHMC Policy "Notification Tree for High Risk/Unusual Incidents" 3/2012
The Joint Commission 2015 Comprehensive Accreditation Manual for Hospitals: The Patient
        Safety Systems Chapter

Complex Care Hospital At Tenaya

Title:	Patient Safety Program	Policy #:	051-37-026.1
Effective Date:	January 2004	Department: Category:	Quality Mgmt Performance Improvement
Revision Date(s)	January 2004, March 2012	Changeability:	☐ Fixed ☒ General

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

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.

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 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.

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. The LifeCare policy, <u>National Patient Safety Goals</u> contains the policy and procedure detailing 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 <u>Handoff Communication Guidelines</u>, Located under Best Practices in LifeCare Policies and Procedures
3. Improve the safety of using high-alert medications as contained in the LifeCare policy, <u>Medication Safety: High Alert Medications</u>
4. Ensure the identification, reporting, prevention and control of infections, including the role of proper hand hygiene as contained in the LifeCare policies, <u>The Infection Control Plan</u> and its addendums; <u>Hand Hygiene</u>, 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, <u>Fall Prevention</u>, 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, <u>Safety – Alarms- Clinical Equipment</u>.
7. Identifying, preventing and correcting errors in the labeling, storing, prescription or administration of medications as contained in the LifeCare policies, <u>Medication Storage</u>, <u>Dispensing – Labels</u>, <u>Dispensing Medications – General</u>, 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, <u>Administration of Drugs</u>, and other policies contained in the Pharmacy section.
9. The identification, investigation and reporting of Sentinel Events as contained in the LifeCare policy, <u>Sentinel Events</u>, 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 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
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 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 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.

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

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II. PATIENT SAFETY PLAN

- Scope of Activities:

  - The scope of the Patient Safety Plan includes ongoing proactive risk assessments, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety.

  - Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis, maybe, but not limited to:

    - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.

    - Mild-Moderate Adverse Outcome Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.

    - Any Medication Variance

    - Any Adverse Drug Reaction

    - Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

    - Sentinel Event: The following events as outlined on NQF Serious Reportable Events in Healthcare:

    - Surgical Invasive Procedure Events

    - Product or Device Events

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- • Patient Protection Events

- • Radiologic Events

- • Care Management Events

- • Environmental Events

- • Potential Criminal Events

- • <u>Near Miss</u> - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

- • <u>Hospital Acquired Conditions (HACs)</u>:

  a. Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, other injuries)

- • The scope of the Patient Safety Plan encompasses the patient population, visitors, volunteers and staff (including medical staff). The plan addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:

  - • Environment of Care

  - • Emergency Management

  - • Human Resources

  - • Infection Prevention and Control

  - • Information Management

  - • Leadership

  - • Life Safety

  - • Medication Management

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- Medical Staff

- Nursing

- Provision of Care, Treatment and Services

- Performance Improvement

- Record of Care, Treatment and Services

- Rights and Responsibilities of the Individual

- Waived Testing

Methodology:

- The Interdisciplinary Safety/Environment of Care Committee is responsible for the oversight of the Patient Safety Plan. The Safety/Environment of Care Committee Chairperson will have administrative responsibility for the plan, or the Safety/Environment of Care Committee may assign this responsibility to another member of the committee.

- All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Director PI/Risk Management, who will aggregate occurrence information and present a report to the Safety/Environment of Care Committee. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety/Environment of Care Committee will analyze the report information and determine further patient safety activities as appropriate.

- Through review of internal data reports and reports from external sources (including, but not limited to, sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the performance improvement priority criteria grid, the Safety/Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually. All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams). The proactive risk assessment will include:

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- Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be

- Prioritizing the potential processes breakdowns or failures

  - For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur

  - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation

  - Test and implement the redesigned process

  - Identify and implement measures of the effectiveness of the redesigned process

  - Implement a strategy for maintaining the effectiveness of the redesigned process over time

- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organizationwide program.

- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:

  - Perform necessary healthcare interventions to protect and support the patient's clinical condition.

  - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others.

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

Preserve any information related to the error (including physical information). Examples of preservation of medication label for medications administered to the incorrect patient.

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Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record <u>as appropriate</u> 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:

  - <u>No Harm Failures or Errors</u> (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.

  - <u>Mild-Moderate Adverse Outcome Failures or Errors</u> (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.

    - <u>Medication Variances/errors</u> - the staff member identifying a medication variance/error (no harm and mild-moderate harm) will notify the Pharmacy Department of the event.

    - <u>Adverse Drug Reaction (ADR)</u> - 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.

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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.

- <u>Hazardous Condition/Patient Safety Issue</u> - 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.

- <u>Sentinel Event</u> - 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.

- <u>Near Miss</u> - 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.

- <u>Hospital Acquired Conditions</u> - staff will follow all established protocols, guidelines and policies and procedures. Staff shall complete incident reports for any breaks in technique or policy not followed.

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

- Further remedial action activities necessary for identified occurrences

- Proactive occurrence reduction activities

- Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

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- 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 <u>required</u> 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 <u>assist</u> 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.

- <u>Sentinel Events</u> - staff members involved in a sentinel event occurrence will receive support from the Safety/Environment of Care Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Safety/Environment of Care Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Service Department, Human Resources Department and/or his/her department supervisor.

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

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

- The Patient Safety Plan includes implementation of the recommendations set forth by the accrediting organization, or identified alternative recommendations defined by this institution, to achieve compliance with established safety standards. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified safety standards.

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	REVISED:

- The Patient Safety Plan includes an annual survey of staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.

- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Safety/Environment of Care Committee will analyze error reporting data submitted through the PI/Risk Management Department for evidence of this information.

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

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

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. Education includes the staff member's right to report any safety or quality of care concerns to the organization's accrediting organization. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

- Lessons learned from a root cause analysis shall be communicated to staff who provide services or are affected by a patient safety incident

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

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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

PATIENT SAFETY PLAN/PROGRAM
CALENDAR YEAR 2016

I.   Purpose:

The Patient Safety Plan is designed to support and promote the mission and vision of Desert Springs Hospital Medical Center (DSHMC), as it pertains to patient, visitor, volunteer, physician, student and employee safety. This plan will be implemented through the integration and coordination of the Patient Safety Council.

The Patient Safety program will promote a patient safe environment that identifies mechanisms that contribute to patient safety, such as a review of high-risk patient care processes, collection and analysis of adverse patient incident data and routine investigation of significant adverse events.

II.   Guiding Statement:

Desert Springs Hospital Medical Center is committed to promoting the safety of all patients, visitors, volunteers, healthcare workers, and students. The hospital-wide Patient Safety Program is designed to reduce medical/health system errors and hazardous conditions by utilizing methods of continuous improvement to support an organizational safety climate that is proactive in its efforts to respond to potential or actual occurrences.

DSHMC Mission Statement:

Desert Springs Hospital Medical Center's mission is to provide quality healthcare services in a safe compassionate and healing environment.

DSHMC Vision Statement:

Desert Springs Hospital will be:
- The hospital of choice in our service area
- A great workplace for our staff
- Known for the excellent service we provide
- A healing environment with emphasis on family-centered care
- An institution with a multicultural focus
- A safe environment for our patients, staff and guests

III.   Creating a Culture of Safety:

In order to take action that will prevent potential or actual patient safety occurrences, it is necessary to have a clear picture of what is actually happening on a systems level so that appropriate steps can be taken that will prevent such occurrences.

A systems approach that emphasizes process review and prevention provides a climate where employees are comfortable to report errors. Systems are investigated to reveal potential and actual failures. We must constantly question if we can do things in a better, more efficient and safer manner. We must force ourselves to look past the easy answer that it was someone's fault, and ask the questions why and how errors occur and more importantly, what can be done to prevent them. It is seldom a single reason.

Accountability, not for zero errors, should be shared among all healthcare workers. Accountability lies not in performing perfectly, but in identifying safety problems, implementing system based solutions, and inspiring and embracing a culture of safety. Employees are held accountable for risky and/or reckless behavior.

IV. Definitions:

Accountability
Accountability is an obligation to provide a satisfactory explanation, or to be responsible, answerable.

Near Miss
Is defined as an unexpected occurrence in which there was no adverse outcome to the patient, but which had the potential to cause serious injury or harm to the patient.

Patient Safety Committee
As defined by NRS 439.875, a medical facility shall establish a patient safety committee. The patient safety committee must be composed of: the patient safety officer of the medical facility, the infection control officer, 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, one member of the executive or governing body of the medical facility. A patient safety committee shall meet at least once each month.

Patient Safety Officer
As defined by NRS 439.815, a person who is designated as such by a medical facility pursuant to NRS 439.870. The Patient Safety Officer shall serve on the Patient Safety Council and supervise the reporting of all sentinel events alleged to have occurred at the medical facility. After receiving notification of a sentinel event the Patient Safety Officer or their designee will report to the State Health Division first within 13 days and then within 45 days of the event as provided by law.

Sentinel Event

Sentinel Event is defined as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or risk thereof", includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Patient Safety Plan
Defined by NRS 439.865, as each medical facility that is located in this state shall develop, in consultation with the providers of health care that provide treatment to patients at the medical facility, an internal patient safety plan to improve the health and safety of patients who are treated at the medical facility.
The patient safety plan must include, without limitation:
  (a) patient flowsheets 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.

A medical facility shall submit its patient safety plan to the governing board of the medical facility for approval. After a medical facility's patient safety plan is approved, the medical facility shall notify all providers of the plan and the requirements of the plan. A medical facility shall require compliance with its patient safety plan.

The DSH Quality/Patient Safety Plan is focused on the five specific concepts associated with high reliability organizations as noted by the Agency for Healthcare Research and Quality (AHRQ). Each of the major actions is linked to one of the five concepts.

Figure 1. The five specific concepts that help create the state of mindfulness needed for reliability, which in turn is a prerequisite for safety
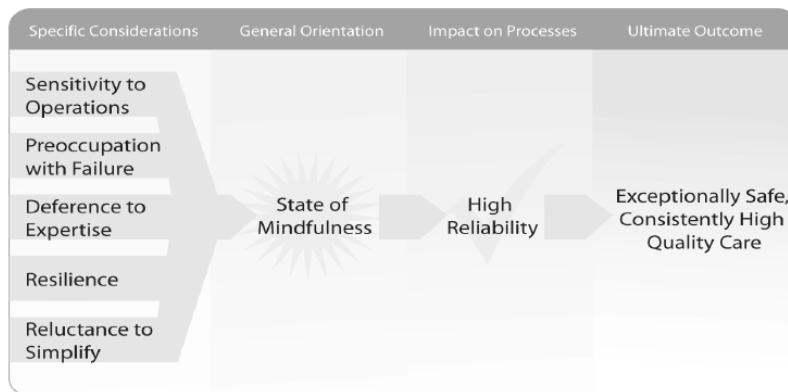
The Patient Safety Plan is a living document that will be assessed, analyzed, reviewed and revised as issues or trends in quality and safety are noted and annually.

Overview:

The leadership of Desert Springs Hospital Medical Center, through the designation of the Patient Safety Council, promotes an organizational safety climate that:

- Encourages recognition, reporting and acknowledgement of risks to patients, visitors, employees, volunteers, and physicians.
- Promotes effective communication among all staff members.
- Initiates and monitors actions taken to reduce these risks/errors.
- Internally reports findings and actions taken.
- Promotes a non-punitive environment for reporting and follow-up of medical errors.
- Recognizes that determining accountability is related to identifying whether an outcome is related to human error, risky or reckless behavior.
- Supports staff members involved in a medical/healthcare error. This support system is available through the Human Resources Department and is in place to assist staff members involved in a sentinel event. Examples of support systems which are in place include: the Employee Assistance Program, debriefing sessions, chaplains, etc. These support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. These support systems focus on the process rather than blaming the involved individuals.
- Educates staff to assure that all members of the healthcare team participate in the program.
- Assures that patients and families are educated about patient safety measures, and are informed about the results of care, including unexpected outcomes and medical/healthcare errors.

V.   Roles and Responsibilities:

Final authority and responsibility for the Patient Safety Program at Desert Springs Hospital Medical Center rests with the Board of Governors. This authority is delegated to the Chief Executive Officer for review and support of the Patient Safety Program activities. The Chief Executive Officer has empowered the hospital leadership and Patient Safety Council with the responsibility for addressing patient safety issues.

VI.   Patient Safety Council:

Universal Health Services adopted the Patient Safety Council initiative in September of 2001. The regulations, composition and frequency of meetings for the Patient Safety Council were subsequently instituted by Desert Springs Hospital Medical Center. The Patient Safety Council shall be composed of:

   a. The infection control officer.
   b. The patient safety officer.

c. At least three providers of health care who treat patients, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff.
d. One member of the executive or governing body.

In compliance with Nevada State law NRS 439.875 the Patient Safety Council shall:

a. Receive reports from the Patient Safety Officer.
b. Evaluate actions of the Patient Safety Officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
c. Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.
d. Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections at the medical facility.
e. Make recommendations to the Executive and Governing Board of the hospital to reduce the number and severity of sentinel events and infections that occur at the medical facility.
f. At least once each calendar quarter, report to the Executive or Governing Board regarding the number of sentinel events and the number and severity of infections that occurred at the hospital during the preceding calendar quarter and any recommendations to reduce the number and severity of sentinel events and infections that occurred at the hospital.

The proceedings and records of the Patient Safety Council are subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.

VII. Scope of the Patient Safety Program:

The Patient Safety Program applies to all hospital employees, volunteers, physicians, and leaders. The Patient Safety Program will monitor and address processes that place patients at risk, are potential near misses, are frequently occurring variances that have the potential to cause harm to patients, and sentinel events.

1. Data from internal monitoring of patient safety:

a. Processes that affect a large percentage of patients
b. Processes that place patients at risk
   ▪ If not performed well
   ▪ High risk, low frequency
   ▪ Low risk, high frequency
   ▪ If performed when not indicated
   ▪ If not performed when indicated
c. Processes that have been or are likely to be problem prone

2.   The type of occurrences to be addressed include, but are not limited to potential and actual events related to:

      a.   Patient safety
      b.   Adverse drug events (medication errors and adverse drug reactions)
      c.   Patient falls
      d.   Hospital acquired pressure ulcers
      e.   Transfusion reactions – blood/blood products administration
      f.   Surgical mishaps
      g.   Unexpected clinical outcomes
      h.   Visitor safety
      i.   Product recalls
      j.   Product/equipment malfunctions
      k.   Customer complaints

3.   Ensure compliance with the 2016 National Patient Safety Goals relevant to acute care hospitals to include the following:

Goal 1:   Improve accuracy of patient identification.
Goal 2:   Improve test result communication to the right staff person on time.
Goal 3:   Improve safety using medications.
Goal 6:   Make improvements to ensure that alarms on medical equipment are heard and responded to timely.
Goal 7:   Reduce the risk of health care infections.
Goal 15: Organization identifies safety risk inherent in its patient population.
- Identify patients at risk for suicide.
Universal Protocol
- Conducting pre-procedure verification process
- Marking the procedure site
- Perform a "Time-Out" immediately prior to starting procedures

VIII.   Annual Report to the Governing Body:

The Patient Safety Council will establish ongoing proactive patient safety monitors in response to UHS Corporate alerts, Joint Commission Sentinel Event Alerts and other recommendations from Joint Commission. Recommendations from Joint Commission, federal, state, or academic bodies and other healthcare organizations will be considered, as appropriate to the organization's services. The recommendations or reasonable alternatives will be implemented.

Other published information and internal aggregate information may also be considered in establishing proactive patient safety monitors. These will be monitored on an ongoing basis and reported to the Hospital Quality Council, Medical Executive Committee and Board of Governors at least quarterly.

IX.   Systems for Internal and External Reporting
        If a medical/healthcare error, near miss, or sentinel event occurs, the incident will be
        reported electronically as soon as the event is discovered in the Midas Program. The
        incident should be reported to the immediate supervisor, Risk Manager and hospital
        administration.

X.   Integrated Components:

        The Patient Safety Council will ensure that all departments and services of the
        organization are integrated into and participate in the Patient Safety Program. Each
        department/service will review sentinel event alert information as it applies to that
        department and incorporate this information into departmental training and competency
        assessment. Each department, as applicable, will be responsible for implementing risk
        reduction strategies, approved by the hospital's leadership, to address the issue(s).

XI.   Response to Sentinel Events:

        The Sentinel Event Policy will be utilized as a resource for immediately responding to a
        sentinel event. The patient will be cared for following the incident according to standards
        of care and practice. Immediate actions will be taken, as appropriate, to minimize risk to
        other patients. The involved staff will be convened, according to time frames established
        in the Sentinel Event Policy, to review the incident and preserve factual information for
        analysis.

        If a sentinel event occurs, a Midas RDE will be completed and reported to the immediate
        supervisor and hospital administration. Proactive risk assessments will be conducted
        through the Patient Safety Council and the Hospital Quality Council in response to
        JCAHO sentinel event information and internal aggregated information.

XIII.   References:

        AHRQ PSNet, Patient Safety Network, Just Culture and High Reliability Unit definitions,
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        Joint Commission on Accreditation of Healthcare Organizations. (2011). No New
National Patient Safety Goals, Only Minor Revisions for 2012. Joint Commission on
Accreditation of Healthcare Organizations. [On-line]. Available: http://jcaho.com.

        Premier Safety Institute. (2002). Comprehensive Medical Safety Program. [On-line].
Available: www.premierinc.com/safety.

Premier Safety Institute. (2002, July). <u>Medical Safety Program Sample Plan</u>. [On-line]. Available: <u>www.premierinc.com/safety</u>.

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	Subject: Patient Safety Plan	
DVH Desert View Hospital	Date of Origin: May 16, 2013	POLICY NO:
	Revision Date: February 24, 2016	
	Department: Quality Assurance	5.005
	Dept. Manager:	
Page: 1 of 9	Chief Nursing Officer:	
	Chief Executive Officer:	

Purpose:
In the long and proud tradition derived from the values of the Rural Health Corporation and focused on the dignity of persons we serve, the Desert View Hospital Patient Safety Plan is designed to improve patient safety, reduce risk and respect the dignity of those we serve by assuring a safe environment. Recognizing that effective medical/health care error reduction requires an integrated and coordinated approach, the following plan relates specifically to a systematic hospital-wide program to minimize physical injury, accidents and undue psychological stress during hospitalization. The organization-wide safety program will include all activities contributing to the maintenance and improvement of patient safety.

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering an environment through their personal example; emphasizing patient safety as an organizational priority; providing education to medical and hospital staff regarding the commitment to reduction of medical errors; supporting proactive reduction in medical/health care errors; and integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

MISSION

The Mission of Desert View Hospital is to serve persons with the greatest care and compassion in a community that celebrates the Gift of Life.

VISION

Vision is evidence of intention and commitment. While Mission describes our foundation, what it is we are about, or how we participate in the health care continuum; our Vision Statement describes what we want to become. It contains our strategy to fulfill our Mission. This is based on the following five basic concepts:

> RESPECT FOR LIFE – We provide compassionate care to the poor, sick, injured, aged and dying regardless of ability to pay.
> PATIENT-FOCUSED – Our Mission is to provide compassionate care to patients, both those who come to us and those to whom we reach out. Decisions are based on what is good for the patient and are not self-serving.
>
> INTEGRATED HEALTH CARE SYSTEM – Services we provide address the continuum of life and are provided through common efforts, recognizing differing roles and responsibilities. Common decision criteria are employed throughout the system, with a common Mission and Vision.

The Vision of Desert View Hospital is to focus on patient health outcomes with changes, improvements and continuous monitoring of activities to ensure that the organization's mission

is consistently supported, assessed, reviewed and revised as necessary over time. To carry on our Mission and to follow through with our Vision, it is necessary we work together as a team. Desert View Hospital's visibility in, and service to, its region will be maintained through the participation from members of the Medical Staff, Governing Body, Employees, and Leadership Team in selected programs and functions.

VALUES

From the mission and vision flow the following values, which permeate all our endeavors:

- Personal worth and dignity of every person we serve regardless of race, color, religion and ability to pay,

- Caring response to the physical, emotional and spiritual needs of the people we serve,

- Decision-making based on ethical principles and social teachings in every activity of the system,

- Collaboration with each other, with physicians and other providers to deliver comprehensive, integrated and quality health care,

- Concern for physical, spiritual, emotional and economic well-being of employees,

- Quality work environments which focus on comprehensive, integrated quality service and opportunities for employee growth,

- Open and honest communication to foster trust relationships among ourselves and those we serve,

- Responsible stewardship of the financial, human and technological resources of the system,

- Leadership in the health fields and in the communities we serve.

Policy:

The policy objectives of the Patient Safety Plan are to:

- Encourage organizational learning about medical/health care errors
- Incorporate recognition of patient safety as an integral job responsibility
- Provide education of patient safety into job specific competencies
- Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame
- Involve patients in decisions about their health care and promote open communication about medical errors/consequences which occur
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk

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- Support sharing of knowledge to effect behavioral changes within Desert View Hospital by sharing of information

Procedure:

ORGANIZATION AND FUNCTIONS

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

A.   The scope of the Patient Safety Team includes medical healthcare errors involving the patient population of all ages, visitors, hospital medical staff, students and volunteers. Aggregate data* from internal (IS data collection, incident reports, questionnaires, ORYX reports, Core Measure reports) and external resources (Sentinel Event Alerts, evidence based medicine, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The severity categories of medical/health care errors include:

- No Harm Error – an unintended act, either of omission or commission, or an act that does not achieve its intended outcome
- Mild to Moderate Adverse Outcome – any set of circumstances that do not achieve the desired outcome and result in an mild to moderate physical or psychological adverse patient outcome
- Hazardous Conditions – any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome
- Near Miss – any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome

The Patient Safety Team will only evaluate aggregate data/processes and NOT specific clinical details related to individual occurrences. Clinical details will be reviewed/addressed through the established Medical Staff Peer Review Process.

B. The Patient Safety Team will be chaired by the designated Patient Safety Officer.

1.   The Patient Safety Officer will be the Director of Quality Resource Management/Risk Manager.

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2. The responsibilities of the Patient Safety Officer include compliance with patient safety standards and initiatives, evaluation of work performance as it relates to patient safety, reinforcement of the expectations of the Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. These duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.

3. Pursuant to Nevada Revised Statute 439.875, primary team membership includes services involved in providing patient care, i.e., Pharmacy, Nursing, at least three providers of health care who treat patients at the medical facility and one member of the executive or governing board.

4. Discussion with the patient/family/caregivers regarding adverse outcomes:

   a. Events impacting the patient's clinical condition – The Patient Safety Officer will notify the care-giving physician about informing the patient/family/caregivers in a timely fashion (within 48-72 hours). Should the care-giving physician refuse or decline communication with the patient/family/caregivers, the Department Chairperson will be notified by the Patient Safety Officer. The patient/family/caregivers will **NOT** be contacted without the permission and/or notification of the care-giving physician involved. The care-giving physician will determine the appropriateness of documentation of the occurrence in the medical record and will communicate this to the Patient Safety Officer.

   b. Events NOT impacting the patient clinical condition, but causing a delay or inconvenience – The Patient Safety Officer will communicate with the Nursing Manager the need for communication with the patient/family/caregiver in the interest of patient satisfaction.

C. The mechanism to insure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

   • Reporting of potential or actual occurrences through the Uniform Occurrence Reporting Policy by any employee in every department.
   • Communication between the Patient Safety Officer and the Facility Safety Officer to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.
   • Reporting of patient safety and operational safety measurements/activity to the Safety Committee.

D. The mechanism for identification and reporting a Sentinel Event/other medical error will be as indicated in Organizational Policies #6-023 (Sentinel Event Policy, implemented 4/98)/6-004 (Incident Occurrence Reporting Policy, implemented 1998), respectively. Any root cause analysis of hospital processes conducted on either Sentinel Events or near

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misses will be submitted for review/recommendations to the Patient Safety Team and the Medical Executive Committee.

E.   As this organization supports the concept that errors occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

- A non-punitive approach and without fear of reprisal, as evidenced by the amnesty policy.

- Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.

- Resources such as Pastoral Care, Social Services, or Human Resources should the need exist to counsel the staff

- Annual staff surveys about their willingness to report medical errors

F.   As a member of an integrated healthcare system and in cooperation with system initiatives, the following Patient Safety Measures will be the focus of Patient Safety activities:

1. Medication Error / Adverse Drug Events
2. Nosocomial Infections
3. Decubitus Ulcers
4. Blood Reactions
5. Slips and Falls
6. Restraint Use
7. AMI
8. Pneumonia
9. DVT/PE

Standardized defined measurements for each of the above is determined through established standards of care. Targets for improvement will be determined by the Patient Safety Committee facility with approval of the Medical Executive Committee. This aggregate data will be reported by the Patient Safety Team at quarterly intervals.

G.   A proactive component of the program includes an annual selection of a high risk or error prone process for concentrated activity, ongoing measurement and periodic analysis. The selected process and approach to be taken will be communicated in a letter to the facility staff.

The selection may be based on information published by JCAHO Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection control, research, patient/family suggestions/expectations or process outcomes.

1. The process will be assessed to determine the steps where there is or may be undesirable variation (failure modes). Information from internal or external sources will be used to minimize risk to patients affected by the new or redesigned process.

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    2. For each failure mode, possible effects on patients, as well as the seriousness of the effect, will be identified.

    3. The process will be redesigned to minimize the risk of failure modes.

    4. The redesigned process will be tested and implemented.

    5. Measures to determine effectiveness of the redesigned process will be identified and implemented. Strategies to maintain success over time will be identified.

H. Implementation of new processes, or redesign of current processes, will incorporate patient safety principles and an emphasis on the important hospital and patient care functions of:

- Patient Rights   Patient/Family Education   Improving Organizational Performance

- Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.

- Resources such as Pastoral Care, Social Services, or Human Resources should the need exist to counsel the staff

- Annual staff surveys about their willingness to report medical errors

G. A proactive component of the program includes an annual selection of a high risk or error prone process for concentrated activity, ongoing measurement and periodic analysis. The selected process and approach to be taken will be communicated in a letter to the facility staff.

The selection may be based on information published by JCAHO Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection control, research, patient/family suggestions/expectations or process outcomes.

    1. The process will be assessed to determine the steps where there is or may be undesirable variation (failure modes). Information from internal or external sources will be used to minimize risk to patients affected by the new or redesigned process.

    2. For each failure mode, possible effects on patients, as well as the seriousness of the effect, will be identified.

    3. The process will be redesigned to minimize the risk of failure modes.

    4. The redesigned process will be tested and implemented.

    5. Measures to determine effectiveness of the redesigned process will be identified and implemented. Strategies to maintain success over time will be identified.

H. Implementation of new processes, or redesign of current processes, will incorporate patient safety principles and an emphasis on the important hospital and patient care functions of:

Patient Rights	Patient/Family Education	Improving Organizational Performance
Patient Assessment	Continuum of Care	Management of Information
Care of the Patient	Leadership	Management of Human Resources

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Infection Control   Management of the Environment of Care

I. The procedures for immediate response to medical health care error are as follows:

1. Staff will immediately report the event to the supervisor (either the nursing manager or the house supervisor if the event occurs during off-hours).

2. The supervisor will immediately communicate the event to the Patient Safety Officer to initiate investigation and follow-up actions. Should this occur during off-hours, the administrator-on-call should be notified and a voice mail message left on the Patient Safety Officer's voice-mail.

3. Staff will complete the Uniform Occurrence Report to preserve information.

4. Staff will obtain required orders to support the patient's clinical condition.

5. The Facility Safety Leader will be notified of any situations of potential risk to others.

6. The Patient Safety Officer will follow usual protocols to investigate the error and coordinate the factual information/investigation for presentation, review and action by the Patient Safety Team.

J. Solicitation of input and participation from patients and families in improving patient safety will be accomplished by:

1. Conversations with patients and families during nursing manager or administrative rounds

2. Comments from Patient Satisfaction surveys

K. Procedures used in communicating with families the organization's role and commitment to meet the patient's right to have unexpected outcomes or adverse events explained to them in an appropriate, timely fashion include:

1. Patient's rights statements

2. Patient responsibilities— A list of patient responsibilities will be included in the admission information booklet. These responsibilities include the patient providing correct information about perceived risks and changes in their condition, asking questions, following instructions, accepting consequences, following facility rules, etc.

3. Annual assessment for information barriers to effective communication among caregivers.

L. Methods to assure ongoing in-services, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:

1. Providing information and reporting mechanisms to new staff in the orientation training

2. Providing ongoing education, including reporting mechanisms, through information presented in in-services

3. Obtaining a confidential assessment of staff's willingness to report medical errors at least annually

4. Testing staff knowledge regarding patient safety in competency testing

5. Evaluating staff knowledge levels and participation of patient safety principles in annual performance appraisals

M. Internal reporting – To provide a comprehensive view of both the clinical and operational safety activity of the organization:

- The minutes/reports of the Patient Safety Team, as well as minutes/reports from the Facility Safety Committee will be submitted through the Director of QRM.

- These monthly reports will include ongoing activities including data collection presented in statistical process control charts, analysis, actions taken and monitoring for the effectiveness of actions.

- The reports will be forwarded to the Medical Executive Committee and to the Desert View Hospital Board of Directors.

N. External Reporting

1. A high risk or error prone process will be selected annually for concentrated activity, ongoing measurement and periodic analysis. The selected topic and approach will reported to Nevada Rural Health Partners.
2. Patient safety measures will be incorporated into the Nevada Rural Health Partners data base for benchmarking purposes.
3. External reporting will be completed in accordance with all state, federal, and regulatory body rules, regulations and requirements.

O. The Patient Safety Officer will submit an Annual Report to the DVH Board of Directors and will include:

1. Definition of the scope of occurrences including sentinel events, near misses and serious occurrences

2. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected

3. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis. (This will be communicated in the facility annual patient safety report due at the May, Board of Directors meeting.)

4. 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.

5. The results of how input is solicited and participation from patients and families in improving patient safety is obtained.

6. The results of the program that assesses and improves staff willingness to report medical health care errors

7. A description of the procedures used and examples of communication occurring with families about adverse events or unanticipated outcomes of care.

8. A description of the examples of ongoing in-service, and other education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

CONFIDENTIALITY

All information related to organizational patient safety performance improvement activities performed by the medical staff or medical center personnel in accordance with this plan are confidential and are protected by the Medical Studies Act.

Confidential information may include, but is not limited to, Patient Safety Team minutes, any associated medical staff committee minutes, organizational performance improvement reports, electronic data gathering and reporting, untoward incident reporting and clinical profiling.

Some information may be disseminated as required by agencies as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proves a "need to know" as approved by the Medical Executive Committee, Medical Center Administration and/or the DVH Board of Directors.

EVALUATION/APPROVAL

The Patient Safety Plan will be evaluated at least every three years or as changes occur, and revised as necessary at the direction of the Patient Safety Team. Annual evaluation of the plan's effectiveness will be documented in a report to the Medical Executive Committee, Chief Executive Officer and ultimately to the DVH Board of Directors.

Risk Management Plan

POLICY	1.19
EFFECTIVE DATE	01/01/2005
PAGES	9
REVISION DATE(S)	01/02; 01/05; 12/07
APPROVED BY:	Name has been removed base on NRS439.843.

CLINICAL PROGRAM MANAGER II

POLICY:

A. This Risk Management Program of Desert Willow Treatment Center in conjunction with the State of Nevada Risk Management Program is an integrated comprehensive proactive program designed to oversee all aspects of risk identification, risk evaluation and coordination of corrective action implementation. The Governing Board supports the development of the risk management process and has delegated risk management functions to the hospital's Facility Supervisor, Quality Assurance Specialist and the Environment of Care Team. All staff, in partnership with the medical staff, are responsible for the safety, health and well being of all patients, visitors and hospital staff and it is therefore the responsibility all providers to work together continuously to promote safe work practices and improve quality of care.

B. The program provides for the coordination of collecting internal and external data on potential hospital risk and reports the analysis and investigation of findings of the hospital's actual and potential risk to the Governing Board, medical staff, administration as well as departments, programs and teams. The reporting mechanism is such that communication is reviewed by all key members of the organization in a timely manner. The process establishes and monitors methods to avoid, eliminate or reduce risks in patient care. The process incorporates the resources of the organization, State of Nevada – Risk Management Division, State of Nevada – Attorney General's Office, external agencies, as appropriate and databases.

PURPOSE:

The purpose of the Risk Management Plan is to document an organized, coordinated and clear manner of identifying risk factors to the hospital, to promote and support development of practices aimed at minimizing the adverse effects of loss, and to reduce, modify, eliminate and control conditions that may cause loss. All risk management activities can be clearly tracked to provide trend data, accountability, program evaluation and establish adherence to standards. The Risk Management Plan also establishes the level of authority and responsibility for decision-making processes and interaction through hospital wide communication.

IMMUNITY:

No individual or institution reporting, providing information, opinion, counsel or services to a medical staff committee, or any medical staff, administration or Governing Board that evaluates quality of care issues or part of the internal risk management program shall be liable in a suit for damages based on such reporting, providing information, opinion, counsel or services provided that such individual or institution acted in good faith and with reasonable belief that said actions were warranted in connection with or in furtherance of the functions of the internal Risk Management Program.

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CONFIDENTIALITY:

Any and all documents and records that are part of the internal Risk Management Program as well as the proceedings, reports and records from any of the above committees shall be confidential and not subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding except for proceedings by the department responsible for disciplinary and/or review action(s) of any professional.

OBJECTIVES:

A. Identify factors that present the potential for injury to patients, visitors or personnel, other risk of hospital liability or damage to hospital property.

B. Minimize the risk of sentinel event occurrence.

C. Minimize the occurrence of situations that can lead to injuries and liability claims.

D. Minimize risk through proactive loss control programs.

E. Control the severity of loss or potential liability when loss occurs.

F. The risk management process is part of Desert Willow Treatment Center's goal for providing the highest quality care to its patients and a safe workplace for personnel. Because factors that may present potential liability problems may be present in any component of the hospital, communication with all departments within the hospital, is an important element of the risk management process.

DATA RESOURCES:

A. Incident/Accident Report (risk identification reporting mechanism)

B. Performance Improvement activities

C. Environment of Care Team Reports

D. Utilization Management referrals

E. External review agencies and databases

F. Claim notification from Medical Records or Business Office Departments

G. Infection Control and Surveillance Reports

H. Administration referral

I. Medical Staff request

J. Patient/family complaints

K. Consumer Surveys

L. Root Cause Analysis of Sentinel Events

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M. Sentinel Event Action Plans

COMPONENTS:

A. Identifying the potential and actual risk in patient care and safety. The incident/accident reporting (risk identification) process is designed to identify, evaluate, trend and report analysis of findings to assist in reducing the frequency of preventable adverse occurrences that may lead to liability claims.

B. Practical application and implementation of the Sentinel Event Policy and Procedure and Root Cause Analysis Plan Policy and Procedure, which requires immediate team analysis of all root causes of any defined sentinel event. A thorough root cause analysis leading to a determined problem resolution action plan will assist in reducing further sentinel events throughout the facility.

C. Through prompt identification and follow-up of these adverse events, risk management activities are conducted as a means of controlling costs of individual claims. Assuring complete documentation for legal defense and early intervention with the patient and family are keys to averting payments for frivolous claims and to controlling the costs of claims where the hospital or physician bear some legal responsibility.

1. Incident/Accident Follow-up: Reported via written report, oral notification, occurrence screening or patient complaint.

2. Four Step Approach to Incident Follow-up:

a   Step 1: Immediate Response:

1). Verify that the patient/staff or other is now receiving appropriate medical management.

2). Review the documentation for completeness, contradictions and clues to the cause. Copy the chart to prevent alterations. Interview those involved.

3). Involvement of appropriate medical staff.

4). Notification of the patient and family by the physician of an untoward event.

5). Preserve any evidence.

6). Notify Administration

b   Step 2: Further Investigation: Gather all pertinent facts about the incidents.

1). Scene - where, when, how, equipment involved, patient and circumstances at the time.

2). Parties - names and addresses of all those involved.

3). Description - include quotes of described events.

4). Damages - extent of injury, extended length of stay, estimated additional medical expenses, loss of earnings, number of dependents, pain and suffering, permanent disability.

5). Assess degree of hospital responsibility.

6). Continue to communicate with the patient and family through the physician, administration or other appropriate entity.

c   Step 3: Loss Control and Loss Prevention:

1). Loss Control:

a). Keep open communication with the patient and family.

b). If appropriate, "write off" a portion of the patient's bill.

c). Develop a risk management case file, with complete, secure documentation.

2). Loss Prevention:

a). Enter incident/accident report into database for trend analysis.

b). Determine, possibly through Performance Improvement Team/risk management analysis/CQI evaluation, if changes in processes, inservice education or other steps are necessary.

d   Step 4: Evaluation of Defensibility Prior to Settlement or Litigation:

1). Communicate with appropriate parties and evaluate how defensible the case would be in court (Standard of Care met, document substantiates care, estimate cost of settlement.)

2). Contact Administrative authorities, claims management representative and/or legal counsel, initiate discussions with the patient and family to reach a settlement.

D. Hospital wide review of incidents/accidents, injuries to patients, real or potential sentinel events and safety hazards shall be reported as evidence of the risk management function. Risk Management reporting system:

1. Governing Board - Performance Improvement Report, sentinel event report, quarterly pending liability suit listing, Risk Management and Safety Report.

2. Performance Improvement Team - PI/Risk Identification Report and Analysis (including any sentinel event and root cause analysis/action plan), PI/Risk Management Interventions Summary Report, Infection Control & Surveillance Monitoring, Medication Error Report Analysis.

3. Environment of Care Team - Safety Analysis Report (including sentinel event report, as appropriate to occurrence), monthly.

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4. Infection Control & Surviellance - infection monitoring.

5. Medical Services Team - Risk Management/Performance Improvement Activities Report (including sentinel event, root cause analysis and action plan).

6. Nursing Performance Improvement - Risk Management/Performance Improvement Report (including sentinel event, root cause analysis and action plan) Patient Questionnaire, Infection Control & Surveillance Monitoring.

7. Quality Assurance Department - concurrent update on risk management cases.

8. Business Office - concurrent risk management case update and pending liability suit.

9. Consumer Surveys - monthly monitoring and quarterly reporting Hospitalwide.

10. Pharmacy and Therapeutics - Medication Error Report, Food Drug Interaction Report, Drug usage report, Polypharmacy report.

E. Operational linkage between performance improvement and risk management functions to facilitate identification, follow-up, and corrective action or prevention of actual or potential problems/needs in patient care and safety, visitor untoward events and personnel illness and injury prevention. Both functions and goals are under the umbrella of the Performance Improvement Department and utilize the same data sources, such as occurrence screening and occurrence reporting, as well as the same peer review processes to assess individual occurrences, problems and trends.

INTEGRATION OF RISK MANAGEMENT AND PERFORMANCE IMPROVEMENT:

RISK MANAGEMENT	**PERFORMANCE IMPROVEMENT**
1. Identifies risk and adverse and sentinel events through occurrence reporting, patient complaints and other data sources.	4. Identifies problems through continuous monitoring of critical indicators of the quality and appropriateness of patient care.
2. Assesses and analyzes (root cause) incidents, adverse and sentinel events and trends through the Performance Improvement Team.	5. Assess performance improvement data through peer review.
3. Recommends and monitors corrective actions designed to reduce patient risks.	6. Monitor effectiveness of corrective actions.

A. Through the performance improvement process, identified problems/needs of hospital staff, programs and medical staff can be resolved with implementation, interventions and evaluation. The risk management and performance improvement functions have accessibility to all necessary, relevant hospital and medical staff data.

B. Safety and Security: Assuring the safe and effective use of hospital equipment depends on the professional responsibility for purchasing equipment, checking prior to use, staff training on use of

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equipment, operating equipment properly, assuring correct settings, reporting problems to the Safety Officer or other appropriate entity, and documented maintenance.

INTEGRATION OF RISK MANAGEMENT AND SAFETY ENGINEERING/SECURITY:

A. The risk management aspects of a safety engineering program include incident/accident reporting and follow-up for equipment related occurrences and/or failures.

B. The safety engineering aspects of the program include prepurchase review, preoperation testing, staff training, preventive maintenance and documentation. In the event of an equipment related occurrence and/or failure, the Safety Officer is responsible, in coordination with State Risk Management, for implementing testing of the equipment by the hospital Maintenance Department or by a qualified independent company.

C. The Safety Officer is responsible for securely storing the identified and tagged piece of equipment and determining if other similar equipment in the hospital should receive a preventive examination. The Safety Officer is responsible for notifying the manufacturer and any other appropriate entity of the malfunction and if a patient injury occurred which may result in a claim. The Safety Officer will determine whether the equipment/device should be repaired and returned to service, held for evidentiary purposes or returned to the manufacturer.

   1. Integration of Risk Management and Education

      a   Accountability and corrective measures for incidents most often involve educational functions. Once the exposure to loss has been identified and priorities set or new policies developed, the Safety Officer, Quality Assurance Specialist and/or the Hospital Administrator may request that an effective educational program with training and retraining will be implemented.

      b   The Safety Officer, Quality Assurance Specialist and/or Hospital Administrator will coordinate, plan and implement educational programs to minimize the risk of harm to patients and others through the general orientation, Risk Management educational sessions as indicated, and coordinate Hospitalwide presentation by the Safety Officer, State Risk Management personnel and or Quality Assurance Specialist.

   2. Integration of Performance Improvement/Risk Management and Patient Relations

      a   The CQI Plan includes functions to evaluate patient feedback, identify individual problems and to take appropriate measures through a reporting system to improve patient satisfaction, enhance the hospital's image and reduce liability losses where patient dissatisfaction is involved. The Quality Assurance Department addresses patient relations and responds directly, or through the appropriate entity, to patient complaints about non-medical problems, and identifies medical problems, such as lack of information and informed consent concerns and refers these matters to the appropriate medical staff member or CQI Team.

      b   The systematic reporting of patient concerns, frustrations, anger or communication breakdowns and the collective response of corrective action(s) will result in both greater patient satisfaction and reduced risk of claims. The role of the Quality Assurance Department, in coordination with Administration, is to determine an appropriate course of action to ensure that optimum care is provided while working

with the department or departments involved in the problem, including the negotiation on behalf of the individuals, providing input toward changes in hospital or department policy and procedure and providing follow-up to ensure that satisfactory resolution has been reached for each individual. Through Quality Assurance and Human Resource Team participation, identified need for inservice education can be arranged and reported and related visitor and patient care activities submitted to hospital Performance Improvement and Human Resources Teams.

3. Business Office: To assist in prompt resolution of financial problems with patients and families, Medical Records, Nursing Department and/or administration works closely with the Business Office to resolve discrepancies in patient billing or insurance claims.

4. Legal Counsel: The Hospital's/Division's legal counsel/Attorney General and Administrative personnel work closely in coordinating and resolving associated problems as a result of an incident/accident prior to it becoming a significant claim. The Deputy Attorneys General and Administrative personnel also coordinate a defensible representation through staff interview, documentation review, preservation of evidence, estimating probable damages and expenses, assessing the degree of hospital responsibility and developing a case file for settlement and/or litigation purposes.

5. Claims Management: Desert Willow Treatment Center's claims management is a function of the State of Nevada's Risk Management Division and the Attorney General's Office.

6. Medical Records: The Hospital's Medical Records Department provides for security of medical records involved in a potential or actual claim and notifies the Hospital Administrator and Quality Assurance Specialist of the receipt of a request for a copy of a patient's medical record due to potential litigation. Administrative personnel work closely with the Medical Records Director in informing Division Administration of any potential or actual claims and assists in providing secure and confidential storage of the medical record.

7. Integration of Risk Management and Medical Staff

   a The Quality Assurance Specialist or designee provides risk-related and potential corrective action reports with follow-up documentation as indicated to selective medical staff through the performance improvement process reporting system.

   b Prompt reporting of medically related adverse events allows the Quality Assurance Specialist, or Hospital Administrator to advise the physician about proper documentation procedures and how to approach and inform the patient and family of an untoward event. The Quality Assurance Specialist, Medical Records Director and/or Hospital Administrator will also assure that all documentation is in order and that an investigation case file is prepared in the event litigation does ensue.

   c The identification and follow-up of medically related incidents will be integrated in to the Hospital's Risk Management and Performance Improvement Programs. The Medical Services Team will review adverse occurrences involving medical care and management, and report findings through the performance improvement process. Through this review process, possible quality and appropriateness of care issues will be managed and opportunities to improve care identified. The medical staff will participate in risk management activities related to the clinical aspects of patient care and safety as follows:

1). The identification of general areas of potential risk and sentinel events in the clinical aspects of patient care and safety.

2). The development of criteria for identifying specific cases with potential risk and/or sentinel events in the clinical aspects of patient care and safety and evaluation of these cases.

3). The root cause analysis with resultant correction of problems in the clinical aspects of patient care and safety identified by risk management activities.

4). The design of programs to reduce risk in the clinical aspects of patient care and safety.

d   Another area of risk management involvement is assuring the implementation of informed consent. Informing the patient of the risk of medication utilization and/or other procedures is part of good medical management, physician's practice and a legal requirement. The physician and/or registered nurse is responsible for the process of informing the patient about risks and hazards of medication and/or other procedures and obtaining the legal custodian's signature on consent forms after the communication process regarding issues requiring informed consent has been completed and documented. The risk management process will review written policy and procedures annually, that are relative to the informed consent process. Policy and procedures shall address the medication and/or other procedures and treatments for which informed consent of the patient, manner of documentation of consent and appropriate persons other than the patient, from whom consent may be obtained.

CREDENTIALING PROCESS, PHYSICIAN PERFORMANCE PROFILE:

A. The physician reappraisal/reappointment system utilizes both risk management and performance improvement activities as the information sources. Through identified areas of risk management that can be used in the medical staff reappraisal/reappointment process, an effective presentation of the physician's performance can more accurately be assessed.

B. The risk management and performance improvement functions will provide reporting of all involvement in any professional liability actions, previously or currently pending challenges to any licensure or registration, the reduction or loss of clinical privileges and final judgments or settlements involving the physician. This profile of the physician's performance will assist in the decision making process for conditions and status of privileges, determination and delineation of privilege additions and deletions in the reappraisal/reappointment process.

1. State, Federal and JCAHO: The Quality Assurance Specialist will assist the Hospital Administration and staff interpreting regulatory standards and assisting with performance compliance standards, including reporting of sentinel events pursuant to organizational Sentinel Event Policy and Procedure.

2. Quality Assurance Specialist Team Involvement:
    (This responsibility is shared with the Director of Nursing)

        a   Governing Board, quarterly report/presentation

        b   Medical Services Team
                   1).   Infection Control
                   2).   Nursing Performance Improvement
                   3).   Pharmacy and Therapeutics
                   4).   Polypharmacy
                   5).   Adverse Drug Reactions

        c   Environment of Care Team

REFERENCES:

Joint Commission
    CAMBHC
        Environment of Care (EC)
        Human Resources (HR)
        Improving Organization Performance (PI)
        Leadership (LD)

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NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)

POLICY AND PROCEDURE

SUBJECT: CONSUMER SAFETY PROGRAM

NUMBER: NN-EC-19   Page 1 of 6

ORIGINAL DATE: 2/18/10

REVIEW/REVISE DATE: 7/18/13

APPROVAL: _____Agency Director

APPROVAL_____Local Governing Body

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I.   PURPOSE

To enhance consumer care delivery and prevent adverse outcomes of care by employing a systematic, coordinated, and continuous approach to the improvement of consumer safety.

II.   POLICY

The Consumer 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.   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. National Quality Forum: www.qualityforum.org.

   4. The Joint Commission National Patient Safety Goals.

   5. NNAMHS Policy NN-EC-08 Safety Management.

   6. NNAMHS Policy NN-IC-06 Hand Hygiene.

   7. NNAMHS Policy NN-IC-07 Standard Precautions.

   8. NNAMHS Nursing Policy 300-1 Administration of Medications.

   9. NNAMHS Form MR 189 Nursing Discharge Instructions.

IV. 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 that did not affect an outcome but for which a
       recurrence carries a significant chance of a serious adverse outcome.

   3. 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:

       a. Surgical site infections.

       b. Ventilator-associated pneumonia.

       c. Central line-related bloodstream infections.

         d. Urinary tract infections.

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 consumer safety as an integral job responsibility.

4. To encourage organizational learning about adverse or potential adverse events.

VI. SCOPE

A.   Areas of focus shall include sentinel events, near misses and other incidents related to:

1. Facility-acquired infections.
2. Medication errors.
3. Adverse drug events.
4. Drug recalls.
5. Other product recalls.
6. Consumer falls.
7. Other consumer 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.   CONSUMER SAFETY COMMITTEE

   A.   The Consumer Safety Committee provides a multidisciplinary forum for the analysis of risk to consumer safety and for the dissemination of information on identified risk for the purpose of improving consumer care.

   B.   Membership shall include:

       1. The Consumer Safety Officer – the Performance Improvement Coordinator.

       2. The Agency Director.

       2. The Director of Nursing.

       4. The Director of Pharmacy Services.

       5. The Infection Control Officer.

       6. The Education Coordinator.

       7. The Facilities Supervisor.

       8. The Medical Director or other member of the medical staff.

       9. A consumer.

   C. The Consumer Safety Committee has adopted consumer safety checklists and policies, including, but not limited to:

       1. Checklists related to specific types of treatment.

       2. Checklists ensuring that the consumer's environment is sanitary.

       3. A discharge checklist which includes instructions concerning aftercare and medications.

       4. Any other checklist which may be appropriate to ensure consumer safety.

       5. A policy for appropriately identifying a consumer with two personal identifiers.

       6. A hand hygiene policy regarding standard precautions.

   D. The Consumer Safety Committee shall meet monthly and shall:

1. Review reports and evaluate the actions of the Consumer Safety Officer on sentinel events and other incidents.

2. Review and disseminate information it receives to the appropriate committees or individuals.

3. Make recommendations concerning identified risks and evaluate the implementation of corrective action plans.

4. Review the patient safety checklists and policies at least annually and revise as necessary.

5. Ensure compliance with the patient safety checklists and policies, which may include:

   a. Hand hygiene monitoring.

   b. Audits of sanitation materials.

   c. Review of medical records.

   d. Performance improvement indicator reports.

   c. Communication to employees.

E. The Consumer Safety Officer shall:

1. Serve on the Consumer Safety Committee.

2. Manage the agency incident reporting system.

3. Report all sentinel events to the Nevada Sentinel Events Registry.

4. Conduct investigations, root cause analyses, and monitor corrective action plans for completion and effectiveness.

5. Take action in collaboration with the Consumer Safety Committee and leadership to ensure the safety of consumers.

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 shall include a summary of any new checklist development, or, revision and use of the checklists and policies.

VIII.   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 seclusion and restraint data.

G. Appropriate implementation of input from consumers, families, and employees.

H. Environmental safety rounds.

I. Environmental safety monitoring by Environment of Care Committee.

J. Reactive analysis (root cause analysis) of incidents.

K. Proactive risk assessment (failure mode effect analysis).

IX.   EMPLOYEE EDUCATION AND TRAINING

A. Employees are educated on safety issues, policies, and procedures during new employee orientation, including department specific orientation.

B. Annual and bi-annual employee education includes safety education.

C. Employees are updated on all new policies or policy revisions.

D. Employees participate on teams for proactive or reactive analysis and are, thus encouraged to participate in the improvement of safety.

SUBJECT: PATIENT SAFETY PLAN	REFERENCE #1004
	PAGE: 1
DEPARTMENT: HOSPITALWIDE	OF: 13
	EFFECTIVE:
APPROVED BY: Board of Hospital Trustees	REVIEWED: OCT 2015

PURPOSE:

- The purpose of the organizational Patient Safety Plan at Grover C. Dils Medical Center is to improve patient safety and reduce risk to patients through an environment that encourages:

  - Integration of safety priorities into all relevant organization processes, functions, services, departments and programs

  - Recognition and acknowledgment of risks to patient safety and medical/health care errors

  - The initiation of actions to reduce these risks

  - The internal and external reporting of what has been found and the actions taken

  - A focus on processes and systems, and the reduction of process and system failures through use of failure mode effect analysis

  - Minimization of individual blame or retribution for involvement in a medical/health care error

  - Organizational learning about medical/health care errors

  - Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations

- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to potential or actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Grover C. Dils Medical Center. The Patient Safety Plan, developed by the interdisciplinary Safety/Environment of Care Committee and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PLAN:

- Scope of Activities:

    - The scope of the Patient Safety Plan includes an ongoing proactive risk assessments, using internal and external knowledge and experience, to prevent error occurrence, maintain and improve patient safety.

        - One high-risk process shall be selected at least every 18 months and a proactive risk assessment shall be performed.

    - Patient safety occurrence information from aggregated data reports and individual incident occurrence reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:

        - No Harm Errors - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome - that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.

- **Mild-Moderate Adverse Outcome Errors** - those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.

- **Any Medication Error**

- **Any Adverse Drug Reaction**

- **Any Transfusion Reaction**

- **Hazardous Condition** - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

- **Sentinel Event** - an unexpected event or occurrence involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

    - The event has resulted in an unexpected death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or

    - An event is one (1) of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):

        - Suicide of any patient in a setting where the patient receives around-the-clock care, or suicide of a patient within 72 hours of discharge

        - Unanticipated death of full term infant

        - Abduction of any patient receiving care

        - Infant abduction or discharge to the wrong family

□ Rape (by another patient, visitor or staff)

□ Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities

□ All identified cases of unanticipated death or major permanent loss of function associated with a healthcare associated infection

■ Hospital Acquired Conditions (HACs):

♦ Serious preventable event - air embolism (never event)

♦ Serious preventable event - blood incompatibility (never event)

♦ Catheter-associated urinary tract infections

♦ Pressure ulcers

♦ Surgical site infections following certain elective procedures, including certain orthopedic surgeries and bariatric surgery

♦ Patient falls (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)

♦ Manifestations of poor control of blood sugar levels, such as diabetic ketoacidosis, hypoglycemic coma

♦ Please check the CMS website for the most up-to-date list of preventable conditions (HACs)

• The scope of the Patient Safety Plan encompasses the patient population, visitors, volunteers and staff (including medical staff). The plan addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:

  ■ Environment of Care

  ■ Emergency Management

  ■ Human Resources

  ■ Infection Prevention and Control

  ■ Information Management

  ■ Leadership

- ■ Life Safety

- ■ Medication Management

- ■ Medical Staff

- ■ Nursing

- ■ Provision of Care, Treatment and Services

- ■ Performance Improvement

- ■ Record of Care, Treatment and Services

- ■ Rights and Responsibilities of the Individual

- ■ Transplant Safety

- ■ Waived Testing

- Methodology:

  - The Interdisciplinary Safety/Environment of Care Committee is responsible for the oversight of the Patient Safety Plan. The Safety/Environment of Care Committee Chairperson will have administrative responsibility for the plan, or the Safety/Environment of Care Committee may assign this responsibility to another member of the committee (such as the Performance Improvement Director or Risk Manager).

  - **All departments** within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Performance Improvement Director, who will aggregate occurrence information and present a report to the Safety/Environment of Care Committee on a monthly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. The Safety/Environment of Care Committee will analyze the report information and determine further patient safety activities as appropriate.

- Through review of internal data reports and reports from external sources (including, but not limited to, The Joint Commission sentinel event report information, ORYX and Core Measure performance data, occurrence reporting information from state and federal sources and current literature), and through the performance improvement priority criteria grid, the Safety/Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually. All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams). The proactive risk assessment will include:

  - Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be

  - Prioritizing the potential processes breakdowns or failures

  - For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur

  - Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation

  - Test and implement the redesigned process

  - Identify and implement measures of the effectiveness of the redesigned process

  - Implement a strategy for maintaining the effectiveness of the redesigned process over time

- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organizationwide program.

- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:

    - Perform necessary healthcare interventions to protect and support the patient's clinical condition.

    - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.

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

    - Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.

    - Report the process/system failure or medical/health care error to the staff member's immediate supervisor.

    - Submit the occurrence report to the Performance Improvement Department per organizational policy.

- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Performance Improvement Department per organizational policy.

- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:

    ■ No Harm Failures or Errors (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an occurrence report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.

    ■ Mild-Moderate Adverse Outcome Failures or Errors (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report - submitting the report to the Performance Improvement Department per organizational policy.

        ♦ Medication Errors - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Department of the event.

    ■ Adverse Drug Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report, submitting the report to the Performance Improvement Department per organizational policy. Staff will also notify the Pharmacy Department.

    ■ Transfusion Reaction - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the Blood/Blood Component Transfusion Reaction Policy and Procedure.

- ■ <u>Hazardous Condition/Patient Safety Issue</u> - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Performance Improvement Department per organizational policy.

- ■ <u>Sentinel Event</u> - 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.

- ■ <u>Near Miss</u> - 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.

- ■ <u>Hospital Acquired Conditions</u> - staff will follow all established protocols, guidelines and policies and procedures. Staff shall complete incident reports for any breaks in technique or policy not followed.

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

  - ■ Further remedial action activities necessary for identified occurrences

  - ■ Proactive occurrence reduction activities

  - ■ Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

- An effective Patient Safety Plan cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences. All staff are <u>required</u> 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 <u>assist</u> 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.

  - <u>Sentinel Events</u> - staff members involved in a sentinel event occurrence will receive support from the Safety/Environment of Care Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Safety/Environment of Care Committee encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Service Department, Human Resources Department and/or his or her department supervisor.

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

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

- The Patient Safety Plan includes implementation of the recommendations set forth by the accrediting organization, or identified alternative recommendations defined by this institution, to achieve compliance with established safety standards. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified safety standards.

- The Patient Safety Plan includes a quarterly survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.

- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Safety/Environment of Care Committee will request a report from the Information Management Committee on a quarterly basis consisting of random record review verifying compliance with informing the patient about outcomes of care. The Safety/Environment of Care Committee will analyze error reporting data submitted through the Performance Improvement Department for evidence of this information.

- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. The Safety/Environment of Care Committee will request a report from the Information Management Committee on a quarterly basis consisting of random record review verifying compliance with this educational process.

- The Patient Safety Plan includes consideration, at least annually, of data obtained from the organizational Information Management Needs Assessment, which includes information regarding barriers to effective communication among caregivers. The Safety/Environment of Care Committee will also request on a quarterly basis, a report from the Information Management Committee identifying the effectiveness of the organization to provide accurate, timely, and complete verbal and written communication among care givers and all other involved in the utilization of data.

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. Education includes the staff member's right to report any safety or quality of care concerns to the organization's accrediting organization. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

- Medical/health care errors and occurrences, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

- Lessons learned from a root cause analysis shall be communicated to staff who provide services or are affected by a patient safety incident. Education shall take place through the Education Department.

- Patient safety reports from the Safety/Environment of Care Committee will be submitted to the organizational Performance Improvement Committee, which exists as the oversight committee for the Safety/Environment of Care Committee. A monthly data report and recordings of meeting minutes will be forwarded to the Performance Improvement Committee, with all information submitted held under the auspices of the Performance Improvement Committee.

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

  - All system or process failures

  - Number and type of sentinel events

  - If patients and families were informed of the adverse events

  - All actions taken to improve safety, both proactively and in response to actual occurrences

  - All results of the analyses related to the adequacy of staffing and actions taken to resolve the identified problem(s)

Harmon Hospital
PATIENT SAFETY PLAN

PURPOSE

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

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering an environment through their personal example; emphasizing patient safety as an organizational priority; providing education to medical and hospital staff regarding the commitment to reduction of medical errors; supporting proactive reduction in medical/health care errors; and integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

OBJECTIVES

The objectives of the Patient Safety Plan are to:

- Encourage organizational learning about medical/health care errors
- Incorporate recognition of patient safety as an integral job responsibility
- Provide education of patient safety into job specific competencies
- Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame
- Involve patients in decisions about their health care and promote open communication about medical errors/consequences which occur
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk

ORGANIZATION AND FUNCTIONS

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

A.   The scope of the Patient Safety Program includes medical/healthcare errors involving the patient population of all ages, visitors, hospital/medical staff, students and volunteers. Aggregate data* from internal (IS data collection, incident reports, questionnaires, reports, and external resources (Sentinel Event Alerts, evidence based medicine, etc.) will be used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The severity categories of medical/health care errors include:

- No Harm Error – an unintended act, either of omission or commission, or an act that does not achieve its intended outcome
- Mild to Moderate Adverse Outcome – any set of circumstances that do not achieve the desired outcome and result in an mild to moderate physical or psychological adverse patient outcome

- <u>Hazardous Conditions</u> – any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome
- <u>Near Miss –</u> any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome
- <u>Sentinel Event –</u> an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome

*The Patient Safety program will only evaluate aggregate data/processes and NOT specific clinical details related to individual occurrences. Clinical details will be reviewed/addressed through the established hospital systems and Medical Staff Peer Review Process as indicated.

B. The Patient Safety Committee will be chaired by the designated Patient Safety Officer.

1. The Patient Safety Officer will be the Director of Quality Management.
2. The Director of Plant Operations will be the Operational Safety Officer.
3. The responsibilities of the Patient Safety Officer include compliance with patient safety standards and initiatives, evaluation of work performance as it relates to patient safety, physical environment, reinforcement of the expectations of the Patient Safety Plan, and acceptance of accountability for measurably improving safety and reducing errors. In conjunction with the departments involved, duties may include listening to employee and patient concerns, interviews with staff to determine what is being done to safeguard against occurrences, and immediate response to reports concerning workplace conditions.
4. The responsibilities of the Operational Safety Officer includes the development and implementation of the 7 Environmental Plans, review of incidents/deviations from the plan and the impact to patient and staff safety.

5. Team membership includes services involved in providing patient care, i.e., Pharmacy, Laboratory, Risk Management, Infection Control, Medical Imaging, Rehab, Nursing and those involved in the environment of care The medical staff representative on the team will be the Medical Director.

6. Discussion with the patient/family/caregivers regarding adverse outcomes:

a. <u>Events impacting the patient's clinical condition –</u>

1) The Patient Safety Officer or designee will notify the care-giving physician about informing the patient/family/caregivers in a timely fashion (within 48-72 hours). Should the care-giving physician refuse or decline communication with the patient/family/caregivers, the Medical Director will be notified by the Patient Safety Officer.

2) The patient/family/caregivers will NOT be contacted without the permission and/or notification of the care-giving physician involved. The care-giving physician will determine the appropriateness of documentation of the occurrence in the medical record and will communicate this to the Patient Safety Officer.

b. <u>Events NOT impacting the patient clinical condition, but causing a delay or inconvenience –</u> The Patient Safety Officer will communicate with the Nursing Director the need for communication with the patient/family/caregiver in the interest of patient satisfaction.

C. The mechanism to insure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines. This is accomplished by:

- Reporting of potential or actual occurrences through the Incident Occurrence Reporting Policy by any employee in every department.
- Communication between the Patient Safety Officer and the Operational Safety Leader to assure a comprehensive knowledge of not only clinical, but also environmental factors involved in providing an overall safe environment.
- Reporting of patient safety and operational safety measurements/activity to the performance improvement oversight through the Medical Executive Committee and Governing Board.

D. The mechanism for identification and reporting a Sentinel Event/other medical error will be as indicated in Incident reporting and the Sentinel Event Policy and Procedure , respectively. Any root cause analysis of hospital processes conducted on either Sentinel Events or near misses will be submitted for review/recommendations to the Patient Safety Committee , and the Medical Executive Committee.

E. As this organization supports the concept that errors occur due to a breakdown in systems and processes, staff involved in an event with an adverse outcome will be supported by:

- A non-punitive approach and without fear of reprisal, as evidenced by the amnesty policy.

- Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.

- Resources such as, Social Services, or EAP should the need exist to counsel the staff

- Annual staff surveys about their willingness to report medical errors

F. As a member of an integrated healthcare system and in cooperation with system initiatives, the following Patient Safety Measures will be the focus of Patient Safety activities:

1) Adverse Drug Events
2) Hospital Acquired Infections
3) Hospital Acquired Decubitus Ulcers
4) Blood Reactions
5) Slips and Falls Staff
6) Patient Falls
7) Restraint/seclusion Use
8) Serious Incident/Event Reports
9) DVT/PE prevention and occurrence
10) Elopements
11) Suicide attempts
12) Patient to patient abuse
13) Patient to staff abuse
14) Staff to patient abuse

Standardized defined measurements for each of the above is determined through the Patient Safety Committee and approved by the Medical Executive Committee and Governing Board. Targets for improvement will be determined and this aggregate data will be reported to the Patient Safety Committee at monthly intervals.

G. A proactive component of the program includes an annual selection of a high risk or error prone process for concentrated activity, ongoing measurement and periodic analysis.

The selection may be based on information published by Joint Commission Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection control, research, patient/family suggestions/expectations or process outcomes.

1. The process will be assessed to determine the steps where there is or may be undesirable variation (failure modes). Information from internal or external sources will be used to minimize risk to patients affected by the new or redesigned process.
2. For each failure mode, possible effects on patients, as well as the seriousness of the effect, will be identified.
3. The process will be redesigned to minimize the risk of failure modes.
4. The redesigned process will be tested and implemented.
5. Measures to determine effectiveness of the redesigned process will be identified and implemented. Strategies to maintain success over time will be identified.

H. Implementation of new processes, or redesign of current processes, will incorporate patient safety principles and an emphasis on the important hospital and patient care functions of:

Patient Rights	Patient/Family Education	Improving Organizational Performance
Patient Assessment	Continuum of Care	Management of Information
Care of the Patient	Leadership	Management of Human Resources
Infection Control	Management of the Environment of Care	

I. The procedures for immediate response to medical/health care error are as follows:

1. Staff will immediately report the event to the supervisor (either the nursing manager or the house supervisor if the event occurs during off-hours).

2. The supervisor will immediately communicate the event to the Patient Safety Officer to initiate investigation and follow-up actions. Should this occur during off-hours the nursing supervisor should initiate and immediate investigation. Information should be obtained by those involved in the event for a root cause analysis.

3. Staff will complete the Incident/Occurrence Report to preserve information.

4. Staff will obtain required orders to support the patient's clinical condition.

5. The Operation Safety Officer will be notified of any situations of potential risk to others.

6. The Patient Safety Officer will follow usual protocols to investigate the error and coordinate the factual information/investigation for presentation, review and action by the Patient Safety Committee, as applicable.

J. Solicitation of input and participation from patients and families in improving patient safety will be accomplished by:

1. Conversations with patients and families during nursing manager or administrative rounds

2. Comments from Patient Satisfaction surveys

K. Procedures used in communicating with families the organization's role and commitment to meet the patient's right to have unexpected outcomes or adverse events explained to them in an appropriate, timely fashion include:

1. Patient's rights statements

2. Patient responsibilities—A list of patient responsibilities will be included in the admission information booklet. These responsibilities include the patient providing correct information about perceived risks and changes in their condition, asking questions, following instructions, accepting consequences, following facility rules, etc.

3. Annual assessment for information barriers to effective communication among caregivers.

L. Methods to assure ongoing inservices, education and training programs for maintenance and improvement of staff competence and support to an interdisciplinary approach to patient care is accomplished by:

1. Providing information and reporting mechanisms to new staff in the orientation training

2. Providing ongoing education,

3. Obtaining a confidential assessment of staff's willingness to report medical errors at least annually

4. Testing staff knowledge regarding patient safety in competency testing

5. Evaluating staff knowledge levels and participation of patient safety principles in performance appraisals

M. Internal reporting – To provide a comprehensive view of both the clinical and operational safety activity of the organization:

- The minutes/reports of the Patient Safety Committee, including operation safety and the management of the 7 environment of care plans will be submitted through the Director of QRM to the Medical Executive Committee.

- These monthly reports will include ongoing activities including data collection presented in statistical process charts/graphs, analysis, actions taken and monitoring for the effectiveness of actions.

1. Following review by the medical executive Committee, will be forwarded to the Governing Board.
2. A high risk or error prone process will be selected at least every 18 months for concentrated activity, ongoing measurement and periodic analysis. The selected topic and approach will be communicated to Patient Safety Committee, Medical Executive Committee and Governing Board.
3. Patient safety measures will be incorporated into the Patient Scorecard.
4. External reporting will be completed in accordance with all state, federal, and regulatory body rules, regulations and requirements.

O. The Patient Safety Officer will submit an Annual Report and will include:

1. Definition of the scope of occurrences including sentinel events, near misses and serious occurrences

2. Detail of activities that demonstrate the patient safety program has a proactive component by identifying the high-risk process selected

3. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis. (This will be communicated in the facility annual patient safety report)

4. 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.

5. The results of how input is solicited and participation from patients and families in improving patient safety is obtained.

6. The results of the program that assesses and improves staff willingness to report medical/health care errors

7. A description of the procedures used and examples of communication occurring with families about adverse events or unanticipated outcomes of care.

8. A description of the examples of ongoing in-service, and other education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

CONFIDENTIALITY

All information related to organizational patient safety performance improvement activities performed by the medical staff or medical center personnel in accordance with this plan are confidential.
Confidential information may include, but is not limited to, Patient Safety Team information, committee minutes, any associated medical staff committee minutes, organizational performance improvement reports, electronic data gathering and reporting, untoward incident reporting and clinical profiling.

Some information may be disseminated as required by agencies as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proves a "need to know" as approved by the Medical Executive Committee and Governing Board

<u>EVALUATION/APPROVAL</u>

The Patient Safety Plan will be evaluated at least every three years or as changes occur, and revised as necessary at the direction of thePatient Safety Committee, Medical Executive Committee and Governing Board. . Annual evaluation of the plan's effectiveness will be documented in a report..

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	Original Date:	07/07
	Revised Dates:	06/10
SAFETY/ENVIRONMENT OF CARE	Reviewed Dates:	03/11, 10/12, 11/15
Reference:	Title: PATIENT SAFETY PROGRAM / PLAN	

PURPOSE:

To improve patient safety and reduce risk to patients at HealthSouth Desert Canyon Rehabilitation Hospital through an environment that encourages:

- Integration of safety priorities into all relevant organization processes, functions and services

- Recognition and acknowledgment of risks to patient safety and medical/health care errors

- The initiation of actions to reduce these risks

- The internal reporting of what has been found and the actions taken

- A focus on processes and systems, and the reduction of process and system failures

- Minimization of individual blame or retribution for involvement in a medical/healthcare 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, collaborative and continuous approach to the maintenance and improvement of patient safety and care through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

The approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at HealthSouth Desert Canyon Rehabilitation Hospital. The Patient Safety Plan, is developed by the interdisciplinary Safety/Environment of Care Committee and approved by the medical staff, Governing Board and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PROGRAM:

Scope of Activities:

The scope of the Patient Safety Program includes an ongoing assessment using internal and external knowledge and experience to prevent error occurrence and maintain and improve patient safety. Patient safety incident information from aggregated data reports and individual incident reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:

- **No Harm Errors** - those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.

- **Mild-Moderate Adverse Outcome Errors** - those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.

- **Any Medication Error**

- **Any Adverse Drug Reaction**

- **Any Transfusion Reaction**

- **Hazardous Condition** - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

- **Near Miss** - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

- **Sentinel Event** - an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function.

HealthSouth Desert Canyon Rehabilitation Hospital's Patient Safety Plan was structured with NRS 439.835 "Mandatory Reporting of Sentinel Events, and NAC 439.900-920 "regulations for Health and Safety of Patients at Certain Medical Facilities.

All of these include attempted occurrences, as they would minimally cause a risk of harm. This data is confidential, based upon NRS 439.840(2) and NRS 439.845(2).

If the unexpected occurrence meets the sentinel event criteria, and occurred on the medical facility's premise, then it must be reported. 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.

The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including medical staff) at HealthSouth Desert Canyon Rehabilitation Hospital. The program addresses maintenance and improvement in patient safety issues in every department throughout the facility.

There will be an emphasis on the following important hospital and patient care functions:
- Ethics, Rights and Responsibilities
- Provision of Care, Treatment and Services
- Medication Management
- Leadership
- Improving Organization Performance
- Management of Information
- Management of Human Resources
- Management of the Environment of Care
- Surveillance, Prevention and Control of Infection

Methodology:

The Interdisciplinary Safety/Environment of Care Committee is responsible for the oversight of the Patient Safety Program.

All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Safety/Environment of Care Committee, who will aggregate occurrence information and present a report to the Performance Improvement/Management of Information Committee on a monthly basis.

The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences, 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.

A review of internal data reports and reports from external sources (including, but not limited to Joint Commission sentinel event report information, rehabilitation performance data, incident reporting information from state and federal sources and current literature), will be presented through the Quality Council/Management of Information priority focus indicators.

The Safety/Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually.

This annual review will be reported to the Quality Council/Management of Information Committee, the Medical Executive Committee and the Governing Board.   All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams see FMEA Policy).

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 could be on the patient.

- Prioritizing the potential process breakdowns or failures.

- For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may have occurred.

- 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.

- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately perform necessary healthcare interventions to protect and support the patient's clinical condition.

- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.

- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary. An Incident Report will be generated at this time. (See Incident Reporting Policy)

- 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; and
- Preservation of information includes documenting the facts regarding the error on an Occurrence Report, and in the medical record <u>as appropriate</u> to organizational policy and procedure.

■ Report the process/system failure or medical/health care error to the staff member's immediate Director/Supervisor, or the Director of Quality/Risk through an Incident Report.

■ The Safety/Environment of Care Committee will review these reports monthly. These reports are then presented to the Quality Council/Management of Information Committee.

■ Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:

- **No Harm Failures or Errors** - (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an Incident Report form, submit the form to the Director Quality/Risk and notify their immediate Director/Supervisor.

- **Mild-Moderate Adverse Outcome Failures or** <u>Errors</u> (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 Director/Supervisor, document facts appropriately in the medical record, on an Incident Report, and submit the report to the Director of Quality/Risk.

- **Medication Errors** - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Department of the event, complete an Incident Report and submit the report to the Director of Quality/Risk.

- **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 Director/Supervisor, document facts appropriately in the medical record and on an Incident Report, and submit the report to the Director Quality/Risk. Staff will also notify the Pharmacy Department.

- **Transfusion Reaction** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the Blood/Blood Component Transfusion Reaction Policy and Procedure.

- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her Director/Supervisor and document the findings on an Incident Report and submit the report to the Director of Quality/Risk.

- **Sentinel Event** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.

- **Near Miss** - staff will report the near miss event to his/her immediate Director/Supervisor, describe the facts of the near miss on an Incident Report and submit the report to the Director of Quality/Risk.

- The Safety/Environment of Care Committee and the Administrative Team will determine the organizational response to process/system failures and/or medical/health care errors and occurrences.

- All sentinel events and reportable near miss occurrences will have a root cause analysis conducted. The determination of the Safety/Environment of Care Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
  - Further remedial action activities necessary for identified occurrences
  - Proactive occurrence reduction activities
  - Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

- All serious incidents will be reported to Corporate Risk/Legal (See Incident Report Policy and Procedure.

An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences.

All personnel are **required** to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Safety/Environment of Care Committee and the individual staff member's Department Director 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 Case Management, Human Resources Department and/or his or her Department Director.

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

The Patient Safety Program includes implementation of the recommendations set forth by the Joint Commission (TJC), or alternative recommendations defined by this institution, to achieve compliance with the Joint Commission established National Patient Safety Goals.

The selected recommendations will be monitored on an ongoing basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified National Patient Safety Goals.

The Patient Safety Program includes safety questions in the patient satisfaction surveys. Responses to the safety questions are reported at the Safety/Environment of Care Committee. This information is analyzed and appropriate intervention taken to improve practice.

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. Staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

Patient safety reports from the Safety/Environment of Care Committee will be submitted to the organizational Quality Council/Management of Information Committee, which exists as the oversight committee for the Safety/Environment of Care Committee. A monthly data report and recordings of meeting minutes will be forwarded to the Quality Council/Management of Information Committee, with all information submitted held under the auspices of the Quality Council.

A quarterly patient safety report will be forwarded to the Governing Board on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.

HEALTHSOUTH®
Rehabilitation Hospital of Henderson

Patient Safety Plan 2015-2016

PURPOSE:

The purpose of the HEALTHSOUTH Rehabilitation Hospital of Henderson Patient Safety Plan is to define the scope, methodology, and leadership commitment of the Patient Safety Program. The Patient Safety Program will be integrated into the existing Safety/Risk Committee, which will analyze and report trending, make recommendations for risk reduction strategies, review internal and external customer feedback, and report findings to Quality Council, Medical Executive Committee, and the Governing Body.

OBJECTIVES:

HEALTHSOUTH Rehabilitation Hospital of Henderson philosophy is to take a proactive approach to the prevention and reduction of medical/healthcare errors. It is recognized that the initiation of effective risk reduction strategies require a focus on processes and systems, and minimization of individual blame or retribution for involvement in a medical/healthcare error. It is the commitment of leadership that it fosters an environment that supports the identification, reporting, and response to potential and actual occurrences. This is achieved through the integration of patient safety priorities into all relevant organizational processes, functions and services, including feedback from customers, and a non-punitive approach to medical/healthcare errors.

The intent of the Patient Safety Program is to assess and develop proactive risk reduction strategies which include:

1. Occurrences within the facility ranging from "near-misses" to sentinel events;
2. Review and evaluation of Sentinel Event Alert newsletter, Joint Commission Perspectives and Joint Commission Patient Safety information for applicability to the facility;
3. Evaluation of types and frequency of sentinel events and root causes, and their likelihood to occur within the facility;
4. Evaluation of historical risk management data for high risk, high volume or problem prone trends in medical care processes, and how they compare or are impacted by clinical and Human Resource issues;
5. Selection of a high risk process annually for pro-active evaluation and re-design, utilizing a Failure, Mode, Effects and Analysis, with Root Cause Analysis included in the process evaluation.
6. Ongoing review of facility policies and plans to ensure a focus on patient safety is clearly communicated.

GOALS:

➢ Accurate patient identification 100% of the time by all clinicians and providers of service

- Clear, concise communication among team members, patient and caregivers, including enforcement of abbreviations not to use, repeat back of verbal orders and critical test results, i.e., panic lab values, abnormal radiology reports and handoff of communication between caregivers
- Standardization of care to minimize variables
- Eliminate nursing access to known high risk medications (i.e., potassium chloride)
- Maintaining an inventory and monitoring of equipment for identified failure, audibility of alarms, malfunction or recalls on products currently used in facility
- Routine preventative maintenance on all equipment, including those which have alarms, to ensure that alarms are audible and up to what distance
- Ongoing review of new products as introduced in facility involving multiple participants in product evaluation
- Staff education on safe use of equipment in the patient care setting
- Identify all hospital acquired infections, treating all unanticipated deaths and/or major permanent loss of function due to infection as a Sentinel Event
- Reporting of all hospital acquired CAUTIs to NHSN
- Reporting of acquired or worsened pressure ulcers to NHSN
- Implementation and enforcement of the CDC Hand Hygiene Guidelines endorsed by TJC as applicable to the facility and approved by the MEC
- Hospital wide vaccination program for employees and LIPs to reduce potential exposure to patients
- Staff education on their individual role in patient safety activities
- Clearly defined Emergency Management policies to include all hazards approach and organizational charts as per HICS, and active involvement of the Medical Staff in emergency management and disaster training activities
- Patient education on their role and ability to provide feedback regarding safety and other concerns within the facility

METHODOLOGY

The facility Leadership and Medical Staff have selected the following indicators to monitor and trend in relationship to Patient Safety:

OUTCOMES
Hospital Acquired Infections
Code Blue
Death/Autopsy/OPO Conversions
Falls with injury

SAFETY
Incident Report Rate
Fall Rate
Medication Errors by type
Restraint Use Rate
Infection Rate

HUMAN RESOURCES
Turnover Rate
Lost Work Days
Work Related Injuries
Needlestick / Sharp Injuries

EOC
EOC – Life Safety
EOC – Safety
EOC – Utilities
EOC – Equipment Management
EOC – Hazardous Materials
EOC – Emergency Mgmt.
EOC – Security

HEALTHSOUTH ®
Rehabilitation Hospital of Henderson

MEDICAL STAFF MEASURES
Informed Consent
Blood Use Appropriateness
PICC Line Placement/discontinuance

In addition, occurrences and opportunities for risk reduction will be ranked based on the severity level assigned on the Incident Report, i.e. Severity Level-CMS Fall Scale: No injury, Injury (except major), Major Injury, and Unknown.

Evaluation of occurrences with a Severity Level of 1 and 2 will consist of, but not be limited to, data collection, analysis of trends, availability and feasibility of risk reductions strategies. Severity Level 3 and 4 occurrences will be evaluated on an individual basis to determine the most effective and efficient method to address the issue. Severity Level 5 and 6 will be analyzed and reported per the Root Cause Analysis and Sentinel Events policies. Process improvement strategies for all severity levels will be evaluated for their effectiveness during implementation and monitored quarterly to ensure risk-reduction strategies have achieved their desired effects. Redesign of processes will be implemented and evaluated as necessary until the desired outcomes are achieved.

PURPOSE:

To improve patient safety and reduce risk to patients at HealthSouth Rehabilitation Hospital of Las Vegas through an environment that encourages:

- Integration of safety priorities into all relevant organization processes, functions and services

- Recognition and acknowledgment of risks to patient safety and medical/health care errors

- The initiation of actions to reduce these risks

- The internal reporting of what has been found and the actions taken

- A focus on processes and systems, and the reduction of process and system failures

- Minimization of individual blame or retribution for involvement in a medical/healthcare 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, collaborative and continuous approach to the maintenance and improvement of patient safety and care through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

The approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at HealthSouth Rehabilitation Hospital of Las Vegas. The Patient Safety Plan, is developed by the interdisciplinary Patient Safety/Environment of Care Committee and approved by the medical staff, Governing Board and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PROGRAM:

Scope of Activities:

The scope of the Patient Safety Program includes an ongoing assessment using internal and external knowledge and experience to prevent error occurrence and maintain and improve patient safety. Patient safety incident information from aggregated data reports and individual incident reports will be reviewed by the Patient Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:

- **No Harm Errors** - those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient.

- **Mild-Moderate Adverse Outcome Errors** - those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.

- **Any Medication Error**

- **Any Adverse Drug Reaction**

- **Any Transfusion Reaction**

- **Hazardous Condition** - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

- **Near Miss** - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

- **Sentinel Event** - an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function.

HealthSouth Rehabilitation Hospital of Las Vegas' Patient Safety Plan was structured with NRS 439.835 "Mandatory Reporting of Sentinel Events, and NAC 439.900-920 "regulations for Health and Safety of Patients at Certain Medical Facilities.

All of these include attempted occurrences, as they would minimally cause a risk of harm. This data is confidential, based upon NRS 439.840(2) and NRS 439.845(2).

If the unexpected occurrence meets the sentinel event criteria, and occurred on the medical facility's premise, then it must be reported. The following are included in the NRS/NAC:

- *Abduction – Removal of a patient of any age by unauthorized person(s) from the medical facility. An attempted abduction is also a reportable sentinel event.*

- *Assault (Attempted Battery) – Crime that is the threat of violence on another person, even if the person is not touched.*

- *Battery- A crime that is any offensive touching of another person with the intent to cause harm.*

- *Burn – Patient death or serious disability associated with a burn incurred from any source, while being cared for in a medical facility.*

- *Contaminated Product/Device- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility. It includes detectable contaminants in drugs, devices or biologics, regardless of the source of contamination and/or product.*

- *Discharge to Wrong Family/Caregiver – Discharge from the medical facility to unauthorized family member(s) or caregiver.*

- *Electric Shock (Environmental) - Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility. (This definition excludes events involving planned treatments, such as electroconvulsive therapies.)*

- *Elopement – Unauthorized/temporary departure, of a patient, from an around-the-clock care setting, resulting in a temporally-related death (suicide, accidental death or homicide) or injury with major permanent loss of function.*

- *Fall – Patient fall that results in an injury with major permanent loss of function or in death as a direct result of injuries sustained in the fall.*

- *Homicide – Crime resulting in patient death. An attempted homicide is also a reportable sentinel event.*

- ■ ***Impersonation of a Health Care Professional*** *– Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.*

- ■ ***Infant Perinatal*** *– Perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams.*

- ■ ***Maternal Intrapartum*** *– Unexpected maternal death related to the birthing process.*

- ■ ***Medication Error(s)*** *– Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional or patient. (Source: NCC MERP).*

- ■ ***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.*

- ■ ***Nosocomial Infection*** *– An unexpected occurrence of a facility-acquired infection is an unanticipated event that is not related to the natural course of the patient's illness (es) or underlying condition(s). A facility-acquired infection is defined as 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 Administrator by regulation pursuant to NRS 439.890.*

The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including medical staff) at HealthSouth Rehabilitation Hospital of Las Vegas. The program addresses maintenance and improvement in patient safety issues in every department throughout the facility.

There will be an emphasis on the following important hospital and patient care functions:
- ■ Ethics, Rights and Responsibilities
- ■ Provision of Care, Treatment and Services
- ■ Medication Management
- ■ Leadership
- ■ Improving Organization Performance
- ■ Management of Information
- ■ Management of Human Resources
- ■ Management of the Environment of Care
- ■ Surveillance, Prevention and Control of Infection

Methodology:

The Interdisciplinary Patient Safety/Environment of Care Committee is responsible for the oversight of the Patient Safety Program.

All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences and potential occurrences to the Patient Safety/Environment of Care Committee, who will aggregate occurrence information and present a report to Administration on a monthly basis.

The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences, occurrence impact on the patient, remedial actions taken, and patient

outcome. The Patient Safety/Environment of Care Committee will analyze the report information and determine further patient safety activities as appropriate.

A review of internal data reports and reports from external sources (including, but not limited to Joint Commission sentinel event report information, rehabilitation performance data, incident reporting information from state and federal sources and current literature), will be presented through the Quality Council, Medical Executive Committee and Governing Board on priority focus indicators.

The Patient Safety/Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually.

This annual review will be reported to the Quality Council, the Medical Executive Committee and the Governing Board.   All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams see FMEA Policy).

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 could be on the patient.

- Prioritizing the potential process breakdowns or failures.

- For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may have occurred.

- 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.

- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately perform necessary healthcare interventions to protect and support the patient's clinical condition.

- As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.

- Contact the patient's attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary. An Incident Report will be generated at this time. (See Incident Reporting Policy)

- 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; and

- Preservation of information includes documenting the facts regarding the error on an Occurrence Report, and in the medical record <u>as appropriate</u> to organizational policy and procedure.

- Report the process/system failure or medical/health care error to the staff member's immediate Director/Supervisor, or the Director of Quality/Risk through an Incident Report.

- The Patient Safety/Environment of Care Committee will review these reports monthly. These reports are then presented to the Quality Council, Medical Executive Committee and Governing Board on a quarterly basis.

- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:

  - **No Harm Failures or Errors** - (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an Incident Report form, submit the form to the Director Quality/Risk and notify their immediate Director/Supervisor.

  - **Mild-Moderate Adverse Outcome Failures or** <u>Errors</u> (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 Director/Supervisor, document facts appropriately in the medical record, on an Incident Report, and submit the report to the Director of Quality/Risk.

  - **Medication Errors** - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Department of the event, complete an Incident Report and submit the report to the Director of Quality/Risk.

  - **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 Director/Supervisor, document facts appropriately in the medical record and on an Incident Report, and submit the report to the Director Quality/Risk. Staff will also notify the Pharmacy Department.

  - **Transfusion Reaction** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the Blood/Blood Component Transfusion Reaction Policy and Procedure.

  - **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her Director/Supervisor and document the findings on an Incident Report and submit the report to the Director of Quality/Risk.

  - **Sentinel Event** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.

- **Near Miss** - staff will report the near miss event to his/her immediate Director/Supervisor, describe the facts of the near miss on an Incident Report and submit the report to the Director of Quality/Risk.

- The Patient Safety/Environment of Care Committee and the Administrative Team will determine the organizational response to process/system failures and/or medical/health care errors and occurrences.

- All sentinel events and reportable near miss occurrences will have a root cause analysis conducted. The determination of the Patient Safety/Environment of Care Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:
  - Further remedial action activities necessary for identified occurrences
  - Proactive occurrence reduction activities
  - Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

- All level 4 or greater incidents will be reported to Corporate Risk/Legal (See Incident Report Policy and Procedure.

An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and occurrences. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and occurrences.

All personnel are **required** to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Patient Safety/Environment of Care Committee and the individual staff member's Department Director 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 Patient Safety/Environment of Care Committee regarding the staff member's professional and emotional reconciliation of the sentinel event. The Patient 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 Case Management, Human Resources Department and/or his or her Department Director.

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

The Patient Safety Program includes implementation of the recommendations set forth by the Joint Commission (TJC), or alternative recommendations defined by this institution, to achieve compliance with the Joint Commission established National Patient Safety Goals.

The selected recommendations will be monitored on an ongoing basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified National Patient Safety Goals.

The Patient Safety Program includes safety questions in the patient satisfaction surveys. Responses to the safety questions are reported at the Patient Safety/Environment of Care Committee. This information is analyzed and appropriate intervention taken to improve practice.

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. Staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

Patient safety reports from the Patient Safety/Environment of Care Committee will be submitted to the organizational Quality Council, Medical Executive Committee and Governing Board, which all exist as oversight committees for the Patient Safety/Environment of Care Committee. A quarterly patient safety data report and recordings of meeting minutes will be forwarded to the Quality Council, Medical Executive Committee and Governing Board on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively. All information submitted will be held under the auspices of the Quality Council.

SUBJECT: Safe Environment Plan - 2016

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.

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.

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

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 all share the responsibility for managing, reporting and investigating incidents.

Reports of patient and visitor incidents/accidents are made using the appropriate forms. These reports are reviewed by the EOC, QAPI and Infection Control. Aggregate information is reviewed by the EOC.

Reports of significant property damage are directed to the SO.

One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

C.   Hazard Surveillance

The Director of Plant Operations (DOPO) is responsible for managing the hazard surveillance process including product safety recalls. Hazard surveillance surveys are conducted to evaluate staff knowledge and skill, EOC compliance, observe current practices, assess/evaluate environmental conditions and other risk factors. Results of hazard surveillance activities serve to improve safety policies and procedures, risk assessments, orientation and education programs and staff performance.

Surveys are conducted on a frequency that meets the needs and requirements of the various areas that are surveyed. All inpatient care areas are scheduled for at least two annual hazard surveillance surveys. Non-patient care areas are scheduled for at least one hazard surveillance survey each year. Areas or systems under special circumstances are scheduled for additional surveys as required.

Additional hazard surveillance surveys are performed during the application of Interim Life Safety Measures (ILSM). Hazard surveillance surveys to assure free and unobstructed exiting for construction projects are performed daily.

The EOC is responsible for oversight of the hazard surveillance program. This includes ensuring that the information received includes an analysis of data collected, identification of trends and patterns, risk reduction strategies, corrective action recommended or taken and persons responsible.

Individual department managers are responsible for initiating appropriate action on findings applicable to their scope of authority or responsibility. The SO is responsible for coordinating follow-up activities with individual department managers to ensure each finding is brought to closure.

D.   Environment of Care Committee

The EOC includes selected members of administration, clinical and support services.

The Safety Officer through the EOC is responsible for managing the process of examining safety issues. Effective use of information is dependent on written and verbal reports from

a number of different functions within Horizon Specialty Hospital. Reports are used to identify and communicate problems, time-sensitive issues and general information about periodic or structured activities to the EOC. Reports help the EOC to prioritize, develop and approve recommendations for improvement of patient, staff and visitor safety. It is the responsibility of the EOC Chairperson to review the content of reports submitted.

The EOC processes information via a discussion of findings and recommendations outlined in the minutes for each meeting. The minutes also document recommendations the EOC has developed and otherwise approved.

E.   Performance Improvement Monitoring

The SO through the EOC has overall responsibility for coordinating the ongoing performance monitoring and the performance improvement monitoring for each of the seven functions associated with Management of the Environment of Care. The SO is responsible for all monitoring associated with the safe environment program.

The intent of establishing performance monitoring is to improve the safe environment program through objective measures of demonstrated performance. **The results of measurement are reported through appropriate channels including the facility's leadership and when appropriate to relevant components of the facility wide patient safety program.** Performance improvement is an important aspect of the Safe Environment Plan. Ongoing performance monitoring serves as an indicator of continued effectiveness of the safe environment program and is a mechanism to identify performance improvement opportunities.

F.   Policies and Procedures

The SO has overall responsibility for coordination of the EOC policy and procedure process including coordination with individual department managers.

Individual department, program, and site managers are responsible for their specific safety policy and procedure process. These safety policies and procedures address issues such as: safe operations, use of hazardous equipment or processes and use of personal protective equipment. The SO assists department managers in development of new safety policies and procedures and participates in reviewing existing policies and procedures.

Organization-wide safety policies and procedures are communicated to staff via normal communication channels. Department managers are responsible for distribution of safety policies and procedures and ensuring they are enforced. Each staff member is responsible for knowing and following all safety policies and procedures.

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 Hospitals have 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 responsibly 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.

I.   Grounds and Equipment

The DOPO is responsible for managing the facilities grounds and external equipment maintenance processes. The Horizon Specialty Hospitals 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, 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

Patients, staff and visitors are prohibited from smoking in all facility regulated buildings and campus.

Plan Evaluation

The Environmental Safety Management Plan will be reviewed on at least an annual basis to ensure that the plan remains consistent with organizational strategies. The designated members of the Senior Team shall recommend revisions or acceptance without revisions. Revisions will be reviewed by the Senior Team, including Clinical Department Directors, the Medical Executive Committee, and the Governing Body.

The Environmental Safety Management Plan for 2016 has been approved

☐ Without revisions

☐ With revisions (which will be reflected in the GB minutes.)

_____

Facilities / Maintenance Director   Date

_____

Chief Executive Officer   Date

_____

Governing Body Representative   Date

Annual Plan
Safe Environment
2016

Safe Environment Plan - 2016

SUBJECT: Safe Environment Plan - 2016

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.

Safe Environment Plan - 2016

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.

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

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

Safe Environment Plan - 2016

Human Resources Director all share the responsibility for managing, reporting and investigating incidents.

Reports of patient and visitor incidents/accidents are made using the appropriate forms. These reports are reviewed by the EOC, QAPI and Infection Control. Aggregate information is reviewed by the EOC.

Reports of significant property damage are directed to the SO.

One of the goals of the reporting process is for the responsible manager to receive facility incident reports as soon as practical after an occurrence. This goal is intended to allow appropriate and timely reporting and follow-up activities as needed.

C.   Hazard Surveillance

The Director of Plant Operations (DOPO) is responsible for managing the hazard surveillance process including product safety recalls. Hazard surveillance surveys are conducted to evaluate staff knowledge and skill, EOC compliance, observe current practices, assess/evaluate environmental conditions and other risk factors. Results of hazard surveillance activities serve to improve safety policies and procedures, risk assessments, orientation and education programs and staff performance.

Surveys are conducted on a frequency that meets the needs and requirements of the various areas that are surveyed. All inpatient care areas are scheduled for at least two annual hazard surveillance surveys. Non-patient care areas are scheduled for at least one hazard surveillance survey each year. Areas or systems under special circumstances are scheduled for additional surveys as required.

Additional hazard surveillance surveys are performed during the application of Interim Life Safety Measures (ILSM). Hazard surveillance surveys to assure free and unobstructed exiting for construction projects are performed daily.

The EOC is responsible for oversight of the hazard surveillance program. This includes ensuring that the information received includes an analysis of data collected, identification of trends and patterns, risk reduction strategies, corrective action recommended or taken and persons responsible.

Individual department managers are responsible for initiating appropriate action on findings applicable to their scope of authority or responsibility. The SO is responsible for coordinating follow-up activities with individual department managers to ensure each finding is brought to closure.

D.   Environment of Care Committee

The EOC includes selected members of administration, clinical and support services.

The Safety Officer through the EOC is responsible for managing the process of examining safety issues. Effective use of information is dependent on written and verbal reports from

a number of different functions within Horizon Specialty Hospital. Reports are used to identify and communicate problems, time-sensitive issues and general information about periodic or structured activities to the EOC. Reports help the EOC to prioritize, develop and approve recommendations for improvement of patient, staff and visitor safety. It is the responsibility of the EOC Chairperson to review the content of reports submitted.

The EOC processes information via a discussion of findings and recommendations outlined in the minutes for each meeting. The minutes also document recommendations the EOC has developed and otherwise approved.

E.   Performance Improvement Monitoring

The SO through the EOC has overall responsibility for coordinating the ongoing performance monitoring and the performance improvement monitoring for each of the seven functions associated with Management of the Environment of Care. The SO is responsible for all monitoring associated with the safe environment program.

The intent of establishing performance monitoring is to improve the safe environment program through objective measures of demonstrated performance. **The results of measurement are reported through appropriate channels including the facility's leadership and when appropriate to relevant components of the facility wide patient safety program.** Performance improvement is an important aspect of the Safe Environment Plan. Ongoing performance monitoring serves as an indicator of continued effectiveness of the safe environment program and is a mechanism to identify performance improvement opportunities.

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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.

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 Hospitals have 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 responsibly 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.

I.   Grounds and Equipment

The DOPO is responsible for managing the facilities grounds and external equipment maintenance processes. The Horizon Specialty Hospitals 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, 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

Patients, staff and visitors are prohibited from smoking in all facility regulated buildings and campus.

Plan Evaluation

The Environmental Safety Management Plan will be reviewed on at least an annual basis to ensure that the plan remains consistent with organizational strategies. The designated members of the Senior Team shall recommend revisions or acceptance without revisions. Revisions will be reviewed by the Senior Team, including Clinical Department Directors, the Medical Executive Committee, and the Governing Body.

The Environmental Safety Management Plan for 2016 has been approved

☑ Without revisions

☐ With revisions (which will be reflected in the GB minutes.)

Name has been removed base on NRS439.843.   1—22-16

Facilities / Maintenance Director   Date

Name has been removed base on NRS439.843.   1/22/16

Chief Executive Officer   Date

Name has been removed base on NRS439.843.   -21-16

Governing Body Representative   Date

HUMBOLDT GENERAL HOSPITAL **CRITICAL ACCESS HOSPITAL** **118 East Haskell St.** **Winnemucca, Nevada 89445**	**POLICY/PROCEDURE:** **#:_____** **Date: 12-15-04** **Revised:02-19-14**
Developed by: Names have been removed **Revised by:** based on NRS 439.843. **Department: Quality Services** **Page 1 of 3 Pages**	**Reviewed:_____** **Approved:_____** **Approved:_____** **Effective: 2\24\14_____**

POLICY: **PATIENT SAFETY PLAN**

POLICY STATEMENT: It is the policy of Humboldt General Hospital to establish measurable objectives for improving patient safety and reducing medical errors. The focus of the plan is on improving patient safety processes and reducing system and process failures, not punitive measures against staff that commit errors. Areas of emphasis in the safety program will include but are not limited to:

1. Informed Consent
2. Patient Identification
3. Unauthorized abbreviations
4. Surgical site verification
5. Preventative maintenance
6. Restraint reduction
7. Medication Administration
8. Blood product administration
9. Staff competency
10. Hand washing
11. Safe Medical Device reporting process
12. Feedback from Patient Satisfaction Survey process
13. Product Recalls
14. Core measure reporting data
15. Compliance with National Patient Safety Goals

I.   **DEFINITIONS:**

    A.   **No Harm Error** – Those unintentional acts, either of omission or commission, or acts that do not achieve their intended outcome – that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, or the potential for a negative outcome, for the patient.

    B.   **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.

    C.   **Any Medication Error, Adverse Drug Reaction or Transfusion Reaction.**

    D.   **Sentinel Event -** An unexpected occurrence involving 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. (NRS 439.830) **See "Sentinel Event Reporting" Policy.**

E. **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.

F. **Hazardous Condition** - Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of serious adverse outcome.

G. **Hospital Acquired Conditions (HACS)** – object left in surgery, air embolism, blood incompatibility, catheter-associated urinary tract infections, pressure ulcers, vascular catheter-associated infection, surgical site infections, patients falls, manifestation of poor control of blood sugar levels, such as diabetic ketoacidosis, hypoglycemic coma,

II. CORE PRINCIPLES:

A. Humboldt General Hospital recognizes that a patient has the right to a safe environment, therefore the organization is committed to undertaking a proactive program to identify processes which may adversely affect patient safety or be associated with medical errors.

B. All departments within the organization (patient care and non-patient care) are responsible to report patient safety occurrences and potential occurrences to the Quality Improvement Director, who will aggregate occurrence information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken and the patient outcome. The Safety Committee will analyze the report information and determine future patient safety activities as appropriate.

C. Our environment will encourage:
  1. "Blame Free" culture where there is a minimization of individual blame or retribution for involvement in a medical error.
  2. Recognition and acknowledgment of risks to patient safety.
  3. Internal reporting of what has been found and the actions taken

C. Daily patient safety "huddle" to include: executive member, chief nursing officer or designee, patient safety officer, pharmacist, infection control officer, medical staff representative, case manager, social services and maintenance representative

D. The Patient Safety Committee will meet quarterly and will include the following members:
  1. Executive Member
  2. Chief Nursing Officer
  3. Patient Safety Officer
  4. Pharmacist
  5. Infection Control Officer
  6. Medical Staff Representative

III. Program Components:
A. Upon identification of a process or system failure and/or medical/health care error:
   1. The patient care provider will immediately perform any necessary healthcare interventions to protect and support the care of the affected patient
   2. Contain the risk to others (example, immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked).
   3. Preservation of physical information related to the error for subsequent analysis (example, removal and preservation of blood bag and tubing for a suspected transfusion reaction; preservation of IV tubing, fluid bag 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 equipment and disposables for injuries during therapy).
   4. The employee/staff member who discovers, or witnesses the event is responsible for documentation and reporting the event. A Quality Review Report will be completed and the staff member completing this documentation will state only the facts.
B. The Quality Services Director, as the designated Patient Safety Officer, is responsible for conducting a root cause analysis for the most critical events.
C. Departments involved in the process or system failure and/or medical care error will review information related to the event and identify and implement measures or process redesign to minimize the recurrence of identified events.
D. Department Supervisors will include departmental activities related to patient safety in their departmental quality improvement program and will ensure staff within their department practice safe processes.
E. The Patient Safety Officer will report all patient safety activities to the Medical Staff and to the governing board, at a minimum, once per year. Information in the report shall include: system and process failures, number and type of sentinel events, actions taken to improve safety, both proactively and in response to actual occurrences and actions taken to resolve identified problems.

	Tahoe Forest Health System	
	Title: Patient Safety Plan	**Policy/Procedure #:** AQPI-02
	Responsible Department: Administration	

Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	Page 1 of 10
☒	Administrative	12/05	1/09; 1/12; 10/13	07/12; 11/13; 02/14; 2/16	
☐	Medical Staff				
☐	Departmental				

Applies to: ☒ System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital

PURPOSE:

To develop, implement, and evaluate a patient safety program for the Tahoe Forest Health System which includes Tahoe Forest Hospital (TFH) and Incline Village Community Hospital (IVCH), (hereinafter referred to as the "organization").

The Tahoe Forest Hospital District (TFHD) Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of this Patient Safety Plan that will identify, evaluate, and take appropriate action to prevent unintended patient care outcomes (adverse events), as well as protect the TFHD's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

This policy is integrated with a companion policy, Risk Management Plan AQPI-04.

The Tahoe Forest Hospital District endorses the National Quality Forum set of "34 Safe Practices for Better Healthcare." Further, the District ascribes to the tenets and practices of the Just Culture program in the investigation of near-misses, adverse events and unexpected/unintended outcomes.

1.0 SCOPE & APPLICABILITY

   1.1 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.

2.0 RECITALS

   2.1 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.

2.2 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.

2.3 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.

3.0 AUTHORITY & RESPONSIBILITY

3.1 <u>Governing Body</u>

3.1.1 The Governing Body, through the approval of this document, authorizes the establishment of 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.

3.2 <u>Senior Leader</u>

3.2.1 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 –o-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.

3.3 <u>Medical Staff</u>

3.3.1 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 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.

3.3.2 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.

3.4 <u>Management Team</u>

3.4.1 The Management Team, through the Director of Quality and Regulations, is responsible for the day-to-day implementation and evaluation of the processes and activities of this Patient Safety Plan.

3.5   Patient Safety Officer (The Pateint Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment C)

   3.5.1   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.

3.6   Patient Safety/Medical Staff Quality Committee

   3.6.1   The Patient Safety Committee shall:

      3.6.1.1   Receive reports from the Director of Quality and Regulations and/or the Patient Safety Officer

      3.6.1.2   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

      3.6.1.3   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

      3.6.1.4   Make recommendations to the executive committee or governing body of the Health system to reduce the number and severity of adverse events that occur

      3.6.1.5   Report quarterly, and as requested, to the executive committee and governing body

      3.6.1.6   The Patient Safety Committee members shall include, at least, the following individuals:

                        3.6.1.5.1.1   Director of Quality and Regulations or the Patient Safety Officer designee, if not one and the same

                        3.6.1.5.1.2   Members of the medical staff

                        3.6.1.5.1.3   One member of the nursing staff (CNO or designee)

                        3.6.1.5.1.4   Director of Pharmacy

                        3.6.1.5.1.5   Medical Director of Quality

                        3.6.1.5.1.6   Risk Manager, if not one and the same as the Patient Safety officer

                        3.6.1.5.1.7   Chief Operating Officer

4.0 PROGRAM ELEMENTS

5.0 Program Goals and Objectives

6.0 Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur

7.0 Promote a safe environment in the Health Systems to alleviate injuries, damages or losses

8.0 Foster communication with patients, employees, medical staff and administration when patient safety issues are identified

9.0 Contribute to PI activities and plans to resolve patient safety issues

10.0 Participate and/or consult on all patient disclosure conferer011nces regarding unexpected/unintended outcomes

11.0 Manage losses, claims or litigation when adverse events occur.

    11.1 Designing or Re-designing Processes

        11.1.1 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.

    11.2 Identification of Potential Patient Safety Issues

        11.2.1 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:

            11.2.1.1 Processes identified through a review of the literature

            11.2.1.2 Processes identified through the organization's performance improvement program

            11.2.1.3 Processes identified through Safety Risk Management Reports (Event Reporting AQPI-06) and sentinel events (Sentinel/Adverse Event AGOV-35)

            11.2.1.4 Processes identified as the result of findings by regulatory and/or accrediting agencies

            11.2.1.5 The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

            11.2.1.6 Adverse events or potential adverse advents as described in HSC 1279.1. (Attachment A)

            11.2.1.7 Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network. (Attachment B)

            11.2.1.8 Adverse events associated with misconnecting intravenous lines, enteral feeding tubes, and epidural lines.

    11.3 Performance Related to Patient Safety

        11.3.1 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:

        11.3.2 The perceptions of risk to patients and suggestions for improving care.

            11.3.2.1 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.

11.3.3 Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.

11.3.4 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.

11.4 Proactive Risk Assessments

11.4.1 Through implementation of this Patient Safety Plan, and integrated with the Risk Management Plan and other performance improvement processes, the Department of Quality and Regulations will systemically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm. Identified opportunities for improvement will then undergo redesign (as necessary) to mitigate any risks identified. A patient safety risk assessment by an external resource will be performed at least every 24 months and reported to the organization as described herein under "reporting structure." A focused patient safety risk assessment will be performed annually by the Patient safety Officer and reported to the organization as described herein under "reporting structure."

11.5 Responding to Errors

11.5.1 The organization is committed to responding to errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization 's response will include care for the involved caregivers as noted below in 4.6.1. To that end, the organization has established a variety of policies and procedures to address these issues,

11.5.2 Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of the Just Culture. Management of these types of errors is described in Sentinel/Adverse Event AGOV-35.

11.6 Supporting Staff Involved in Errors

11.6.1 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: (Support for Employee Caregivers Involved in Sentinel or Adverse Events AHR-110)

11.7 Educating the Patient on Error Prevention

11.7.1 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.

11.8 Informing the Patient of Errors in Care

11.8.1 The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/families is described in the Administrative policy, Disclosure of Unanticipated Adverse Outcome to Patients/Families AGOV-15.

11.9 Reporting of Medical Errors

11.9.1 The organization has established mechanisms to report the occurrence of medical errors both internally and externally.

11.9.2 Errors will be reported internally to the appropriate administrative or medical staff entity.

11.9.3 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 AGOV-35.

11.10 Evaluating the Effectiveness of the Program

11.10.1 On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.

Related Policies/Forms: Sentinel/Adverse Event AGOV-35; Event Reporting AQPI-06; Disclosure of Unanticipated Adverse Outcome to Patients/Families AGOV-15; Support for Employee Caregivers Involved in Sentinel or Adverse Events AHR-110; Risk Management Plan AQPI-04; The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"
References:
Policy Owner: Director, Quality & Regulations
Approved by: Chief Operating Officer

Attachment A

Reportable events – The below chart depicts those events that are specifically identified by the states of California and Nevada as reportable events. This list is **not all inclusive** and is only offered as a guide. Any event that meets the definition of a sentinel event MUST be reported to the Quality Services Department for evaluation.

Event	California	Nevada
Wrong site surgery - 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.	X	X
Wrong patient surgery - Surgery performed on the wrong patient.	X	X
Wrong surgery procedure - 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 at to preclude the obtaining of informed consent	X	X
Retention of a foreign object – Foreign object left 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.	X	
Death during or up to 24 hours after induction of anesthesia – Death 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.	X	
Contaminated Product/Device - 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.	X	X
Patient death or serious disability associated with a device - The use or function of a device in patient care in which the device is used or functions other than as intended. For purposed of the subparagraph, "device" included, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.	X	
Air embolism - 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	X	
Infant discharge to the wrong family/caregiver	X	X
Child discharge to the wrong family/caregiver		X
Adult discharge to the wrong family/caregiver		X

Event	California	Nevada
Elopement- Patient death or serious disability associated with patient disappearance for more than four hours. California specifically excludes events involving adults who have competency or decision-making capacity.	X	X
Suicide or attempted suicide - 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.	X	X
Medication error- 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.	X	X
Transfusion - A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.	X	X
Maternal - 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.	X	X
Hypoglycemia - Patient death or serious disability directly related to hypoglycemia, the onset which occurs while the patient is being cared for in a health facility.	X	
Hyperbilirubinemia in infants - 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	X	
Decubitus ulcer - A stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.	X	X
Spinal manipulation - A patient death or serious disability due to spinal manipulative therapy performed at the health facility.	X	
Electric shock - A patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a health facility	X	X
Wrong Gas - Any incident in which a line designated for oxygen or other gas to be delivered to patient contains the wrong gas or is contaminated by a toxic substance	X	X
Burn - A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility	X	X
Fall - A patient death or serious disability associated with a fall while being cared for in a health facility. Nevada also specifically requires reporting of fall that results in an injury with major permanent loss of function.	X	X

Event	California	Nevada
Restraint - A patient death or serious disability associated with the use of restraints or bedrails	X	X
Impersonation of a Health Care Professional - Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider	X	X
Abduction - The abduction of a patient of any age. In Nevada an **attempted** abduction is also reportable.	X	X
Rape - The sexual assault on a patient within or on the grounds of the facility	X	X
Attempted Rape		X
Procedure complication - An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor	X	X
Assault (attempted battery) – Crime that is the threat of violence on another person, even if the person is not touched, that occurs within or on the grounds of the facility.		X
Battery – Crime that is any offensive touching of another person with the intent to cause harm that occurs within or on the grounds of the facility.		X
Homicide and attempted homicide – Crime resulting in patient death. An attempted homicide is also reportable.		X
Infant Perinatal – Perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2500 grams		X
Treatment Delay – Patient failed to receive necessary treatment in accordance with facilities policies and procedures, and the standards of care for the indicated treatment.		X
Treatment Error – Patient received incorrect treatment or indicated treatment was performed incorrectly.		X
Nosocomial Infection – An unexpected occurrence of a facility acquired infection in an unanticipated event that is not related to the natural course of the patient' illness or underlying disease. Includes surgical site infections, ventilator associated pneumonia, central line related bloodstream infections, urinary tract infections.		X

Attachment B

Reportable events – The below chart depicts those events that are specifically identified by the CDC as determined to be preventable.

Event	California	Nevada
Central Line-associated Bloodstream Infections	X	X
Clostridium difficile Infection	X	X
Surgical Site Infection	X	X
Catheter-associated Urinary Tract Infection	X	X
Ventilator-associated Pneumonia	X	X

Strategic Quality Operational Plan

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SECTION I

Commitment to Quality

Kindred's commitment to key quality indicators are aligned with and driven by our Mission, Vision, Values, Critical Success Factors, and our Management Philosophy. The Strategic Quality plan incorporates research and evidence from a variety of sources including the Institute for Healthcare Improvement (IHI), the Agency for Healthcare Research and Quality, the National Quality Forum and others.

Our Mission

Kindred Healthcare's mission is to promote healing, provide hope, preserve dignity and produce value for each patient, resident, family member, customer, employee and shareholder we serve.

Our Vision

Kindred Hospital Division's Vision is to be the hospital company of choice in the post-acute hospital setting and to provide a level of service and quality that is unequaled in the field.

Our Values

- Give your best
- Respect individuality to create team
- Be kinder than expected
- Do the right thing
- Treat others the way they want to be treated
- Create fun in all that you do
- Stay focused on the patient
- Take responsibility for every action you make

Critical Success Factors

- Manage Capital Wisely
- Be Efficient
- Grow
- Take Care of our People
- Organizational excellence through performance improvement
- Take care of our patients and customers

Kindred Management Philosophy

Focus on our people, on quality and customer service, and our business results will follow

Quality Aims

Our Strategic Quality Plan is the roadmap to excellence. The foundational underpinnings to Quality at Kindred are based on 5 Quality AIMS, adapted from the Institute of Medicine's (IOM) landmark report *Crossing the Quality Chasm*, the Institute for Healthcare Improvement's (IHI) Triple Aims, and Agency for Healthcare Research and Quality's (AHRQ) National Quality Strategy:

I. Patient Centered
II. Well Led
III. Safe and Reliable
IV. Smooth Transitions of care
V. Value Driven

Implementation of the Strategic Quality Plan is a strategy to mold the culture into one that values the Quality AIMS. Clinical programs, patient care processes and practices are evidence-based and focus on reducing variation and improving outcomes.

AIM I - Patient Centered Care

AIM One is an unwavering focus on patient's needs and expectations
- Care that is coordinated, informed and grounded in respectful interactions with care providers that are consistent with the patient's values, expectations and care decisions
- Care is efficient through appropriate use of resources at the least expense to the patient, provider and care setting
- Care is timely and provided without delay to mitigate any harm to a patient

Patient-centered care requires regular re-examination of the "Voice of the Customer" to gain ongoing feedback and insight about the effectiveness of processes critical to the patient.

AIM II - Safe, Reliable, Predictable and Regulatory Compliant

AIM Two is to provide care, which is safe, reliable and meets regulatory standards
- Delivery of care in a manner that minimizes the risk of harm to a patient
- Effective and reliable through use of evidence-based practices
- Ongoing compliance with regulatory and accreditation standards'
- Monitoring and Self-Assessment to ensure a continued state of survey readiness
- Compliance with mandatory reporting requirements

It is a core operational responsibility for every executive and every person providing and supporting care in our hospitals to ensure an environment where care is safe, effective and centered on patients' needs.

AIM III - Well-Led

AIM Three is to be well led with a bias towards action by clinical and operational leaders to achieve quality and safety objectives.
- Leaders set direction by aligning and coordinating strategic priorities and key initiatives
- Leaders build the foundation for execution by hiring, mentoring and retaining competent, quality-driven key leaders.
- Leaders who are quality driven effectively identifying issues, allocating resources, ensuring accountability and leading the execution of operational processes to maintain quality
- Leaders are visible conducting leadership rounding that ensures an understanding of needs, barriers and expectations of patients, families, and staff.

Leaders set expectations for continuous improvement by never being satisfied with anything less than the best.

AIM IV - Smooth Transitions of Care

AIM Four is to ensure smooth transitions of care during the hospital stay and to the next site of care. A standardized approach to key meetings ensures a safe, smooth and effective patient-centric approach during all transition of care **(Appendix D: Data Reporting Procedures)**
- Interdisciplinary Team (IDT) meetings ensure care planning begins upon admission and includes the development of discharge plans for each patient.
- IDT meetings are focused on "completing the care" to assure patients receive the right care at the right time and in the right place. The team utilizes a quality crosswalk **(see APPENDIX C for location of IDT Quality Crosswalk)** to ensure outcomes are viewed and discussed in "real time."
- Daily Transitions meetings track progress in order to maintain continuity of care and services needed to achieve treatment goals, eliminate barriers and facilitate the transition to the next level of care.

Identifying preventable delays that may prolong the hospital stay enhances patient satisfaction and continually creates patient value.

AIM V - Value-Driven

AIM Five is to provide care that is patient centered while adding patient value, conserving resources and avoiding waste.
- Resource utilization decisions, particularly in terms of additional new resources, should be evaluated as to the value added to the patient.
- Process improvement efforts work to eliminate non-value added steps hence improving performance and reducing cost.

- Hospital performance is compared to other hospitals within Kindred and external organizations or benchmarks, to achieve a best in class standard of excellence.

The leadership team must align all improvement activities with the strategic AIMS for the organization and identify gaps in activities and infrastructure that would be barriers to reaching goals.

- Clarify accountability for processes and outcomes throughout the organization
- Build the infrastructure for regular review and alignment of new and on-going initiatives, through data collection, analysis and reporting structures
- Create and publish a hospital-wide view of how key improvement activities and strategies throughout the organization align with strategic goals and aims. Make the Balanced Scorecard visible!
- Create reward and recognition systems for attainment of goals aligned with the strategic aims, assuring that the systems contribute to gain for the whole organization

SECTION II
Scope, Authority and Responsibilities

The Strategic Quality Plan provides the structure and processes for identifying, responding to, and implementing opportunities to fulfill our commitment to organizational excellence and the achievement of our Quality Aims. This quality plan is the central performance improvement plan in the organization and encompasses the inter-related functions and processes of clinical care, governance, operational and support services. Leaders foster performance improvement through planning, educating, setting priorities, providing appropriate time and resources and by constantly focusing on the primary tenets of the Strategic Quality Plans Quality Aims.

The Committee Structure is standardized to ensure consistent, transparent and effective implementation and oversight. The structured process:

- Facilitates a consistent unified structure to meet Strategic Quality Plan goals and objectives.
- Ensures an effective process for implementing the Hospital's QAPI program.
- Promotes transparent communication to the Quality Council, Medical Executive Committee and Governing Board.

The standardized Committee Structure, which includes standardized committee dashboards, provides a transparent method for data collection, aggregation, analysis and review of quality of care and safety concerns at the primary committee level. Utilization of the committee standardization process facilitates integration of quality and patient safety throughout the hospital through self-identification of issues, development of interdisciplinary action plans, to include physicians, and monitoring for rapid cycle improvement. The leadership of the facility, Quality Council, Medical Executive Committee, and Governing Board has the ultimate responsibility for monitoring and oversight of the effectiveness of the QAPI process. **(See Section VI)**

Governing Body

The ultimate responsibility for performance improvement rests with the Hospital Governing Board. The authority and responsibility for the day-to-day operations and performance improvement activity is delegated to the Hospital Quality Council and hospital leadership, including the leadership of the Medical Executive Committee.

Quality Council

The Hospital Quality Council is the central coordinating body for all performance improvement and patient safety activities within the hospital. The Quality Council meets regularly to ensure oversight of quality activities within the hospital. <u>The President of the Medical Staff (or designee) shall serve as Chairperson and the Chief Executive Officer shall serve as Vice-Chairperson</u>. Membership includes representation from both Medical Staff and various leadership positions; Medical Staff Members must be present (telephonically, if necessary).

The Quality Council coordinates the performance improvement process by:

- Establishing a planned, systematic, organization-wide approach to performance measurement, analysis and improvement.
- Utilizing Quality Council (QC) Committee structure that supports the implementation of the hospital-wide improvement process to include the following:
  - ➢ Planning the process of improvement activity to meet quality patient safety goals
  - ➢ Determining the scope and focus of measurement
  - ➢ Setting priories for improvement
  - ➢ Systematically measuring, analyzing and directing performance improvement
  - ➢ Implementing improvement activities based on assessment conclusions
  - ➢ Maintaining achieved improvements
- Standardized dashboards are utilized to ensure all performance improvement activities are reviewed in the appropriate QC Committee <u>prior to</u> review at Quality Council meetings. Committee configurations may vary according to size of facility, but standard dashboards covering established functions will be followed.
- Setting expectations for leadership and staff participation in interdisciplinary and interdepartmental performance improvement and patient safety activities.
- Allocating resources for the hospital's performance improvement and safety activities. Commissions/convenes performance improvement teams and approval of project selection for specific improvement efforts and monitors its progress.
- Ensuring that processes for identifying and managing serious and sentinel patient safety events are defined and implemented.
- Implementing and monitoring compliance with the National Patient Safety Goals (NPSG).
- Evaluating the effectiveness of the Strategic Quality Operational Plan and the effectiveness of leadership's contributions to performance improvement and patient safety at least annually. **(See Appendix C for location of Quality Council Evaluation)**

First Level Working Committees (also see Section VI)

First level working committees report to the Quality Council using specified dashboards with established meeting frequencies (minimum meeting frequency is quarterly). The first level working committees ensure substantive analysis of data and action planning occurs prior to review at Quality Council. These committees work to conduct data review and analysis as well as action planning and tracking and trending of action plans effectiveness on results.

This continuous flow of information and feedback ensures that quality of care and safety concerns are brought forth and addressed by the appropriate individuals and committees responsible for quality assurance and improvement activities.

The Medical Staff

The medical staff has a leadership role in organizational performance improvement and patient safety activities, particularly when a process is dependent primarily on the activities of individuals with clinical privileges. The Medical Staff Bylaws describe the expectations of members of the Medical Staff and allied health practitioners (AHPs) and their roles in quality improvement. The Medical Staff Rules and Regulations are expected to conform to the Medical Staff Bylaws.

The medical staff provides leadership in the areas of performance improvement and patient safety including though not limited to:
- Medical assessment and treatment of patients.
- Use of medications including safe ordering, transcription, dispensing and administration of medications.
- Outcomes related to resuscitative services
- Utilization of services and clinical products (i.e. operative and other procedure(s), blood products)
- Appropriateness and significant departures from established patterns of clinical practice
- Accurate, timely, and legible completion of patients' medical records
- Other activities as specified in the Medical Staff By-Laws

SECTION III

Quality Framework

Integrating Performance Improvement methodologies and tools is essential to a systematic approach to continuous process improvement. Continuous improvement is an ongoing effort to improve products, services or processes. These efforts can seek "incremental" improvement over time or "breakthrough" improvement all at once. **PDCA** is used to coordinate improvement efforts through emphasis on planning. The PDCA cycle goes from problem identification to implementation of the solution.

P: Plan, determine what the improvement will be and the method for data collection.
D: Do, implement the plan.
C: Check, review, and analyze the results.
A: Act, hold the gain and continue with the improvement

Act:
Keep the change or go back to planning.

PLAN the test of change via activities, actions, process steps (examples):
- Flowchart current processes.
- Determine the cause and effect of why you do what you do (to identify barriers).
- Flowchart a streamlined process removing waste or steps.

Check the results of the change:
- Find out from people involved what happened.
- Identify positives and negatives.
- Measure and compare before and after results.
- Is the result/outcome better?
- Was the defined goal met?

Do implement the change:
- Make sure all staff involved are aware of the plan.
- Make sure the Administrative team is on board and supportive of plan.

PDCA should be repeated for continuous improvement. If the solution does not improve the process, it is removed and the cycle is repeated with a different plan. If the solution does improve the process, it is standardized and the new process system knowledge is used to implement new improvements, beginning the cycle again.

Performance Improvement Teams (PIT) are convened when specific hospital-wide or interdepartmental issues are identified. The purpose of the PIT is to perform intensive analysis using a planned, systematic, organization-wide approach that facilitates designing, measuring, assessing and improving performance, using the PDCA methodology. Dependent upon the complexity of the process for improvement or design, other models may be selected such as process re-engineering, Rapid Cycle Improvement methods, etc.

Telling Your Quality Story through Data Visualization

Aggregation and analyses transform data into information that can be used to plan, change or monitor care. Performance is compared against industry standards, internal benchmarks, comparable external organizations and best practices in order to determine patterns and trends. Information from data analyses, process review and performance improvement efforts are used to make changes that improve performance, increase safety and reduce risk of a sentinel event occurring.

The utilization of statistical tools and methods in the analysis process is an expectation. Their use allows us to display data in different ways to uncover specific kinds of information, such as performance over time and performance depending on certain variables. When data is organized in a chart format, trends, patterns and relationships emerge. Charts give us a way to summarize large amounts of data at a quick glance. Different tools are designed for different purposes but all are generally designed to help us better understand our processes and the variation inherent in them. By understanding the type and cause of variation through the use of statistical tools and methods, the organization can focus its attention and resources on making improvements to the processes that will result in better outcomes.

The main goal of data visualization is to clearly and effectively communicate the information and performance through graphical means. When telling the story, the focus should be on providing visual analysis of data sets and communicating key aspects in an intuitive way. Example tools used to tell the story include:

Flow Charts: Flow charts show all steps in a process and give people a visual of the "big picture" so they see how each step is related to the next. Flow charts also help identify the most efficient way to complete a task or process:

Pareto Charts: Pareto charts are bar graphs that show in descending order how often a situation occurs. They identify consistent or frequent problems, and they help the team decide where to begin the improvement process.

Scatter Diagrams: Scatter diagrams show relationships between occurrences, situations, or actions. They allow the team to identify variables and the ways these variables affect the outcome.

Fishbone Diagrams: Fishbone diagrams are visuals used to show cause and effect. They help people explore what, when, and why therapy went wrong (or right).

Control Charts: Control charts, also known as Shewhart charts, are tools used to determine if a process is in a state of statistical control. Data are plotted in time order. It always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data.

Trend lines: A trend line visually identifies both trends and random variations in data. The more points used to draw the trend line, the more validity attached to the direction represented by the trend line.

SECTION IV

Using Outcomes to Drive Performance

Quality Assurance and Performance Improvement (QAPI) is a philosophy that encourages all members of a facility to identify new and better ways to do their job. The single best indicator of the effectiveness of the QAPI is the ability of a hospital to self-identify quality issues. Integrating self-assessment methodologies into everyday work processes makes for an efficient way to collect data and identify where systems are falling short, to make corrective adjustments, and to track outcomes.

The following Kindred processes are examples of concurrent *self-assessment* activities performed to evaluate compliance to regulatory and accreditation standards as well as key internal policies and procedures.

Examples of Self-Assessment Activities:

Tracers: Tracers are designed to "trace" the care experiences that a patient had while at Kindred or "trace" one specific process within the organization (i.e., complaint/grievance process). It is a way to analyze the system or process using actual patients as the framework for assessing compliance. While individual tracers follow a patient through his or her course of care, the system tracer evaluates the system or process, including the integration of related processes, and the coordination and communication among disciplines and departments in those processes. The results of tracers are used to formulate an action plan to address any identified deficiencies or issues.

Leadership Rounding: Rounding for outcomes is one of the skills used to better serve our patients, physicians and staff. Leaders round to build relationships, assess employee morale, harvest wins and identify and remove barriers that prevent staff from doing their jobs. Leadership rounding brings a different set of eyes and ears to the patient's bedside on a regular basis. As a result it presents an opportunity for service recovery, allows for gathering of information for staff reward and recognition, and helps connect leaders to our mission of serving patients.

Complaint and Grievance Process: A process to timely review, investigate, and resolve a patient's dissatisfaction. In addition to meeting regulatory requirements, a complaint and grievance process is an essential part of the quality program through identification of trends and patterns within the clinical and customer service program.

Quality Assurance (QA)/Quality Control (QC) Audits: QA audits may be a systematic review of care against explicit criteria (prevention of "defects"). QC audits are used to identify "defects" (temperatures, lab QCs, etc.). Departments use audits specific to their own PI goals. Regulatory audits may be specific to State and Federal expectations. The results of QA audits are often used to calculate rates for benchmark and other key performance indicators.

Quality and Regulatory Review (QRR) and Survey Readiness Visits (SRVs): The Division (through regional clinical operations and plant operations contract partners conducts formal onsite and offsite reviews to determine survey readiness in meeting The Joint Commission (TJC) accreditation

standards and Centers for Medicare/Medicaid Services' (CMS) Hospital Conditions of Participation. QRRs rely heavily on patient and system tracers to evaluate the organization's potential performance during a survey.

Interdisciplinary Team (SQP/IDT crosswalk): The interdisciplinary team oversight and discussion of quality of care services, risk reduction and prevention opportunities, resource appropriateness and efficiency, and patient & family education allows for rapid cycle improvement opportunities. It also facilitates a concurrent review for accurate clinical documentation as a way to provide a clear story of each patient's care.

Flash/Daily Transitions/Care Plan Management Meetings: Daily Flash meeting is a CEO led interdisciplinary forum for daily evaluation of operations (e.g., staffing, patient change of conditions, equipment needs, plant issues, etc.). Daily Transitions meetings is a CCO led interdisciplinary forum for daily evaluation of 1) details related to timely follow up of patient care plan needs and 2) safe, organized transitions to next levels of care. These meetings allow for a concurrent evaluation of multiple performance indicators.

Failure Modes and Effects Analysis (FMEA): A proactive step-by-step approach for identifying all possible failures in a design, process, or a product or service. "Failure modes" means the ways, or modes, in which something might fail. Failures are any errors or defects, especially ones that affect the customer, and can be potential or actual.

Hazard Vulnerability Analysis (HVA): Provides a systematic approach to documenting potential threats that may affect demand for the hospitals services or its ability to provide those services. It is an essential component to a risk assessment, particularly related to emergency operations in a disaster.

Satisfaction Surveys: Patient, Employee and Physician feedback allow for identification of what your customers think is important, what they want, and where you need to improve. Patient safety culture surveys evaluate whether quality and safety are core values in the organization.

Annual Plans: This scheduled activity provides a consistent evaluation that highlights the achievements and continued challenges facing specific clinical programs such as Infection Prevention and Control, Risk Management, Environment of Care and Education.

Event/Error and Near Misses Analysis: Reporting of errors in a just culture environment allows individuals to report errors or near misses without fear of reprimand or punishment. This allows for identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior. Analysis with or without event calls can lead to identification of process change needs.

Clinical and Service Indices: A composite of several indicators into a single measure. Provides a quick self-assessment of several key division indicators.

Mortality Review: Review of patient deaths to evaluate clinical practice patterns and identify significant departure from established patterns of clinical practice.

Findings from the above (and other) self-assessment strategies trigger the performance improvement methodology used to drive change. The flow diagram depicted in Figure 1 is the typical process used. In summary, the process is such that self-assessment results are either evaluated by a department leader or DQM, and in collaboration with the CCO, who determine an appropriate PI project plan. If the results involve clinicians from more than a single department a decision is made to commission a PDCA project, either via a rapid cycle process or a more traditional Quality Council sanctioned Performance Improvement Team (PIT) project.

Rapid cycle is applying the recurring sequence of PDCA in a brief period of time to solve a problem or issue facing the team that will achieve breakthrough or continuous improvement results quickly.

If the results are to be reviewed and analyzed for committee recommended actions, Quality Council would commission and prioritize a formal PIT PDCA project. These QC sanctioned PIT projects typically include those improvements that are more organization-wide oriented (involves multiple departments), may require input from outside subject matter experts, and just generally command more time and human resources making the process slower and more methodical. Additionally, the Quality Council determines the prioritization of the performance improvement teams needed based on specific criteria. Performance Improvement Teams report progress and/or results through the Quality Council committee structure.

A PI project may begin as rapid cycle but evolve to a formal QC sanctioned PIT because of additional information obtained and a necessity to have more organizational level oversight.

Figure 1: PI Process

This same process is used when improvement opportunities are identified from external agencies (e.g., complaint survey, triennial accreditation survey, health department inspection). The goal, however, is to integrate an ample number of the right kind of self-assessments that provide a satisfactory sampling of current processes that are considered to be high risk, problem prone, low volume, etc.

See **Appendix C** for Location of Example PI Tools:

SECTION V

Quality Indicators

Quality indicators (or measures) are important as a way to document the outcomes of care, treatment and services provided and to identify opportunities for improvement. Kindred Hospitals annually determine the indicators it will use to measure performance as well as set corresponding goals. This process is done via one of two mechanisms:

a) Key Quality Indicators are those measures hard-wired on the agendas/dashboards of the first level working quality committees. These indicators are not optional and must be measured and reported on a frequency established by the quality committee (generally tracked monthly, reported quarterly). These indicators are often a condition of a regulatory or accreditation requirement but can also include items that are important to the patient population served.
- A subsection of the key quality indicators are those core measures which all Kindred hospitals track with the expectation that the results will be compared to other Kindred Hospitals as well as national comparative benchmarks or databases. These key indicators are chosen as a result of an evidence-based look at the patient population served and are determined to have the greatest influence on outcomes of care.

- Key quality indicators also include those areas that assess compliance with federally-mandated measures such as CMS' Quality Reporting Program (QRP) reporting requirements or IMPACT Act Requirements for 2018 (new/worsened PW).

Key quality indicators are expected to be measured and reported despite level of compliance. Goals are set by the hospital unless the dashboard includes a goal or threshold that is expected to be used (Appendix B identifies the goals/thresholds set by the hospital and which are set as a common goal to be used by all hospitals).

b) Hospital-Specific Quality Indicators are chosen by the facility due to the significance related to one of its own key success factors, results of self-assessment activities, quality control processes, other high-risk high/low volume, problem-prone, or patient safety issues.

- Department-specific performance indicators are chosen based on a process or system that department(s) want to improve.
- Self-assessment activity findings may trigger a need to add an indicator to one of the first level working quality committee agendas in order to draw attention to an improvement needed. A rapid cycle PDCA or QC commissioned PIT PDCA project may be warranted.
- Critical check list findings (CEO and CCO checklists) and quality control results may trigger a need to add an indicator to one of the first level working quality committee agendas in order to draw attention to an improvement needed. A rapid cycle PDCA or QC commissioned PIT PDCA project may be warranted.

Once sustained compliance is achieved data collection and reporting on that indicator may conclude. Goals or thresholds are set by the hospital.

- In the case of department-specific indicators, the indicator that has achieved sustained compliance should be replaced with another improvement indicator.
- Self-assessment findings (including CEO & CCO checklists) or external agency deficiency findings that have been corrected with sustained compliance do not need to be replaced with another quality indicator.

Refer to the **Appendix B** for a complete library of Key Quality Indicators. Hospital-specific quality indicators can be added to the list locally or kept separately.

There are no specific requirements for a total number of indicators. A single indicator may fulfill the obligation for several categories (CLABSI is a key indicator on the Balanced Score Card, a CMS-QRP metric and meets the TJC requirement for monitoring infection control practices). Hospitals achieving desired performance targets, specifications or thresholds on hospital-specific measures may choose to change measures at any time, once performance levels are achieved and sustained.

Compliance to quality indicators is documented and presented to committee one of three ways:

1. <u>Numeric Goal</u>: A numeric goal includes a numerator and denominator. The numerator and denominator need to be explicit with regard to what is included or excluded in the measurement. For example, the numerator of mortality rate is total number of deaths for a month. The denominator is total number of discharges for that month. That definition must be followed exactly as written to ensure data validity. For example, changing the denominator to include only all non-hospice discharges would significantly change the result.

2. <u>Summary Report</u>: Those goals that are not numeric in nature are best evaluated through a summary report that demonstrates trends and patterns in outcomes achieved. For example, a Code Blue summary report allows for presentation of multiple elements included in that quality indicator. Some of the elements might be numeric, others might be non-numeric targets. The summary format allows for inclusion of key anecdotal notes, qualitative characteristics, and general observations, etc.

3. <u>Existing Report</u>: The Balanced Score Card and Benchmark Report are examples of static reports or queries available from the Business Warehouse (BW) that can be presented to a committee meeting as is. Analysis and action plans are added to these reports to demonstrate appropriate oversight and management of the data.

SECTION VI
Committee Structure

The Quality Council is the coordinating body for all hospital-wide quality assurance and performance improvement activities and processes. The Quality Council's Committee Structure supports implementation of the Quality Plan utilizing first level working quality committees with specified agendas, standardized dashboards and minimum meeting frequencies to ensure substantive analysis occurs prior to review at Quality Council. First level working committees report findings, analyses, recommendations, actions and follow up specific to the individual committee's functions.

Three first level working quality committees support the work of the Quality Council and cover all or parts of the following functions:
- Patient Safety and Reliability Committee
  o Pharmacy Nutrition and Therapeutics (PNT)
  o Infection Prevention and Control (IP&C)
  o Patient Care & Safety (including Critical Care, Operative & Invasive Procedures)
  o Laboratory / Radiology
- Leadership Committee
  o Leadership
  o Environment of Care (EOC)
  o Ethics
- Value Driven Transitions Committee
  o Utilization Management (UM)
  o Health Information Management (HIM)

Standardized Dashboards are utilized to help organize, track and trend key and hospital-specific quality indicators, monitoring activities and improvement efforts. Data are collected and reported on a frequency established by the first level committee (generally reviewed monthly and reported quarterly) to the designated first level committee. Subcommittees (often functional subcommittees such as PNT or HIM) may be designated to support the collection, aggregation, analyses and monitoring activities of a first level committee. Subcommittee summary forms are included in the Dashboard workbooks for documentation of subcommittee work that occurs between the quarterly first level committees. Hospital-specific quality indicators or performance improvement activities can be added to a specific dashboard at any time at the discretion of the hospital.

Credentialing activities may warrant more frequent meetings than quarterly to expedite applications and reapplications. The subcommittee summary form should be used to document discussions and recommendations between quarterly MEC meetings as well as for ad hoc (tele board) Governing Board approval activities.

When committee or monitoring findings fall outside of the parameters of expected or desired performance, an action plan is developed at the committee level. The PDCA process is utilized and clear responsibilities assigned. Proven strategies for prevention such as the Institute for Healthcare Improvement (IHI) Ventilator-Associated Pneumonia, Blood-Stream Infection and Catheter-Associated Urinary Tract Infection Bundles serve as the foundation for relevant improvement plans.

The Quality Council may determine additional actions or requirements are needed and redirect such actions to the working committees. Performance Improvement Teams may be convened by the Quality Council for significant and/or hospital-wide performance issues. Performance Improvement Teams will report progress and results to the Quality Council. The Quality Council will monitor compliance of the action plans and timelines as necessary.

This continuous flow of information and feedback encourages involvement from the individuals who are closest to the work and the committees they represent while having appropriate oversight by the leaders who are ultimately accountable for the quality assurance and improvement activities and program.

SECTION VII

Appendices

Appendix A: Terms / Definitions

Aggregate

A process for displaying data in a spreadsheet to provide results over time. Patterns and trends related to performance and/or compliance are identified and can then be analyzed.

Analysis

A process of interpretation and summarization of the data for a specific time period. The time frame may be determined based on the indicator or previous findings.

Clinical Quality Index

A composite of two or more indicators into a single metric used to measure performance in clinical care and outcomes.

Control Chart

A graphic display of data in the order they occur with statistically determined upper and lower control limits of expected common-cause variation.

Balanced Scorecard

Kindred Healthcare's key success factors scorecard. The indicators are reviewed with targets set on an annual basis.

Benchmark

A standard or point of reference against which things may be compared or assessed. Benchmarking is the process of comparing processes and performance metrics to best practices from other companies.

Benchmark Report

The title of one set of quality indicator data that is housed in Business Warehouse (such as Vent Admits, Vent Days, Restraint Days, CVL Days etc.).

Business Warehouse (BW)

Kindred Healthcare's Data Repository. Software that integrates, manages and stores data within the company from various data sources. Allows for business planning and analysis through data mining and visualization. Data entry is performed monthly for those elements that are not able to be compiled automatically.

CARE Data Set (Continuity Assessment Record and Evaluation)

A standardized patient assessment tool developed for use at acute hospital discharge and at post-acute care admission and discharge. The CARE Data Set is designed to standardize assessment of patients' medical, functional, cognitive, and social support status across acute and post-acute settings, including long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs).

Daily Flash Meeting

A CEO led interdisciplinary forum for daily evaluation of operations (e.g., staffing, patient change of conditions, equipment needs, plant issues, etc.).

Daily Transitions Meeting

A CCO led interdisciplinary forum for daily evaluation of 1) details related to timely follow up of patient care plan needs and 2) safe, organized transitions to next levels of care.

Dashboard

Standardized tools utilized throughout the quality council reporting structure to help organize, track and trend key and hospital-specific quality indicators, monitoring activities and improvement efforts.

Data

Un-interpreted material, facts, or clinical observations.

Failure Mode, Effects, and Analysis (FMEA)

A systematic approach for identifying the ways that a process can fail, the potential effects of such a failure and the seriousness of that effect, resulting in a process or system redesign to minimize the risk of failure.

GAP analysis

Comparison of actual performance with potential or desired performance.

IMPACT Act

On September 18, 2014, Congress passed the *Improving Medicare Post-Acute Care Transformation Act of 2014* (the IMPACT Act). The Act requires the submission of standardized patient assessment data related to quality measures, resource use, and other measures. The data elements are standardized across post-acute settings to facilitate coordinated care and improve Medicare beneficiary outcomes.

Indicator

A measure used to determine, over time, an organization's performance of functions, processes, and outcomes. Therapists rate patients' abilities to complete specific functional tasks as part of assessments in both LTAC and Nursing Centers.

Performance Improvement (PI)

The continuous study and adaptation of a health care organization's functions and processes to increase the probability of achieving desired outcomes and to better meet the needs of individuals and other users of services.

Performance Measure

A quantitative tool generally defined as regular measurement of outcome results which generates reliable data on effectiveness and efficiency of a specified process.

Patient Safety Index

A composite of two or more indicators into a single metric used to measure performance in areas important to Patient Safety.

Patient Satisfaction Index

A composite of two or more indicators into a single metric used to measure performance in customer service or satisfaction.

Plan of Correction (POC)

Specific, clearly defined steps or plans developed to eliminate identified root causes or implement new processes.

Quality Control (QC)

Quality control (QC) is a procedure or set of procedures intended to ensure that a product or performed service adheres to a defined set of quality criteria or meets the requirements of the customer. QC is similar, but not identical to, quality assurance (QA).

Quality Regulatory Review (QRR)

A hospital division program designed to determine survey readiness in meeting The Joint Commission (TJC) accreditation standards and Centers for Medicare/Medicaid Services' (CMS) conditions of Participation.

Quality Reporting Program (QRP)

The IMPACT Act of 2014 requires the specification of quality measures for the LTCH QRP, including such areas as skin integrity, functional status, such as mobility and self-care, as well as incidence of major falls. Beginning in FY 2014, the applicable annual update for any LTCH that did not submit the required data to CMS was reduced by two percentage points.

Root Cause Analysis

A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

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.

Tracer Methodology

A method used to "trace" a patient's care experience or a process using actual patients as the framework for assessing compliance. Individual Patient Tracers follow a patient through his or her course of care. System Tracers evaluate the systems or processes, including the integration of related processes, and the coordination and communication among disciplines and departments in those processes.

Appendix B: Key Quality Indicators Definitions, Formulas and Targets

(Target = Expected Goal, Threshold = Minimum Expectation, Comparative Reference = A reference to use for goal setting)

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
1. Mortality Rate	$$\frac{\text{Number of deaths}}{\text{Total number of discharges for month}} \times 100$$	Comparative Reference: **14.64%** (Kindred HD Oct. YTD 2015)
2. Wean Rate	$$\frac{\begin{array}{c}\text{Number of discharges for the month who were admitted* on a vent}\\ \text{and were weaned for > 72 hours during the admission**}\end{array}}{\begin{array}{c}\text{Total number of patients discharged who were admitted on the}\\ \text{ventilator***}\end{array}} \times 100$$ * Admitted on a vent = All patients admitted on a ventilator or placed on a ventilator within 7 days of admission. ** Only the 1st successful wean episode counts. *** As determined by daily vent charges that are dropped (use of drilldown on Benchmark report will indicate a 'N' for each patient that is excluded from the denominator (no vent charge) and a 'Y' for each patient that is included in the denominator (vent charge). For example, *BiPAP via vent* is not expected to count in the denominator yet since a vent is in use a charge may drop inadvertently adding this patient to the denominator count. In this case, incorrect charges must be corrected by the facility prior to the 8th of the month in order for Calculated Wean Rates to be correct Patients who are transferred out of our hospital for < 72 hours for a procedure/treatment at another hospital is not considered a discharge for the purposes of this indicator. **Please Note:** **Although the successful wean is "counted" at the time of discharge, it makes no difference if the patient is on or off the ventilator at the time of discharge. If the patient was successfully weaned (off the ventilator for > 72 hours) once during the admission, it counts as a wean. If a patient is subsequently placed back on the ventilator at any time during the admission, it will not be counted, in the numerator or the denominator, again.** **Inclusions** Numerator: Patients off vent >72 hours and placed on Trach collar or T-piece is a wean. **Exclusions** Numerator: Nocturnal vent is not a wean. Denominator: NIPPV is not a vent episode. Excludes all patients going on the vent > 7 days of admission. Weans that later die are successful weans. Ignore repeated episodes of ventilation. **NO exclusions for chronic vent admissions.** NOTE: Risk-adjusted outcome algorithms may vary slightly from above.	Comparative Reference: **49.19%** (Kindred HD Oct. YTD 2015)

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
3. Infection-Related Ventilator-Associated Event (VAE)	**NHSN Definition-01/2016** (http://www.cdc.gov/nhsn/pdfs/pscmanual/10-vae_final.pdf) $\underline{\text{# Episodes of IVAC in ventilated patient}}$ X 1000 Total number Ventilator days **Ventilator-Associated Condition (VAC)** Patient has a baseline period of stability or improvement on the ventilator, defined by ≥ 2 calendar days of stable or decreasing daily minimum* FiO2 or PEEP values. The baseline period is defined as the 2 calendar days immediately Preceding the first day of increased daily minimum PEEP or FiO2. *Daily minimum defined by lowest value of FiO2 or PEEP during a calendar day that is maintained for **at least 1 hour**. After a period of stability or improvement on the ventilator, the patient has at least one of the following indicators of worsening oxygenation: 1) Minimum daily FiO2 values increase ≥ 0.20 (20 points) over baseline & remain at or above that increased level for ≥2 calendar days. 2) Minimum daily PEEP values increase ≥ 3 cmH2O over baseline and remain at or above that increased level for ≥2 calendar days. **NOTE:** It is important to use the date the patient was placed on the ventilator when entering in NHSN. **DO NOT** use the date of admission unless that is the day the patient was intubated. If the patient comes to Kindred and you cannot get the date of first ventilation you can estimate the date. **Infection-related Ventilator-Associated Complication (IVAC)** On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, the patient meets **both** of the following criteria: 1) Temperature > 38 °C (100.4F) or < 36°C (96.8F), **OR** white blood cell (WBC) count ≥12,000 or ≤4,000 cells/mm3. **AND** 2) A new antimicrobial agent(s) is started, and is continued for ≥ 4 calendar days. **Possible Ventilator- Associated Pneumonia (PVAP)** (Possible and Probable VAP combined) On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, ONE of the following criteria is met (taking into account organism exclusions specified in the protocol): □ **Criterion 1**: Positive culture of one of the following specimens, meeting quantitative or semi- quantitative thresholds as outlined in protocol, without requirement for purulent respiratory secretions: • Endotracheal aspirate, ≥ 10^5 CFU/ml or corresponding semi-quantitative result • Bronchoalveolar lavage, ≥ 10^4 CFU/ml or corresponding semi-	Comparative Reference: (Kindred HD Oct YTD, 2015) **IVAC: 0.36 per 1000 ventilator days** Comparative Reference: NHSN = **As of 12/2015 NHSN has not published VAE data**

quantitative result

- Lung tissue, ≥ 10^4 CFU/g or corresponding semi-quantitative result
- Protected specimen brush, ≥ 10^3 CFU/ml or corresponding semi-quantitative result

□ **Criterion 2:** Purulent respiratory secretions (defined as secretions from the lungs, bronchi, or trachea that contain >25 neutrophils and <10 squamous epithelial cells per low power field [lpf, x100])† plus a positive culture of one of the following specimens (qualitative culture, or quantitative/semi-quantitative culture without sufficient growth to meet criterion #1):

- Sputum   • Endotracheal aspirate   • Bronchoalveolar lavage
- Lung tissue   • Protected specimen brush

† If the laboratory reports semi-quantitative results, those results must correspond to the above quantitative thresholds. See additional instructions for using the purulent respiratory secretions criterion in the VAE Protocol.

□ **Criterion 3:** One of the following positive tests:

- Pleural fluid culture (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube)
- Lung histopathology, defined as: 1) abscess formation or foci of consolidation with intense Neutrophil accumulation in bronchioles and alveoli; 2) evidence of lung parenchyma invasion by fungi (hyphae, pseudo hyphae or yeast forms); 3) evidence of infection with the viral pathogens listed below based on results of immunohistochemical assays, cytology, or microscopy performed on lung tissue
- Diagnostic test for Legionella species
- Diagnostic test on respiratory secretions for influenza virus, respiratory syncytial virus, adenovirus, parainfluenza virus, rhinovirus, human metapneumovirus, coronavirus

Inclusions:

Patients on BiPAP via Tracheostomy

Exclusions:

Skilled Nursing Units (SNU) and Subacute Units (SAU)

PLEASE REFER TO THE CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTION DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY or the **NHSN DEFINITIONS at:**
http://www.cdc.gov/nhsn/PDFs/pscManual/pcsManual_current.pdf

4. New or worsening Pressure Ulcers	Patients with Pressure Ulcers That Are New or <u>Worsened on Discharge CARE Assessments</u> **X 100** Number of Discharge CARE Assessments	Comparative Reference: (2015 November YTD) **Kindred HD = 2.08** **LTRAX Nation = 1.81**

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
	Measures "Percent of Patients with Pressure Ulcers that are New or Worsened" following CMS QRP reporting rules. Excludes expired patient discharge CARE Assessments.	

5. Central Line Associated Blood Stream Infection (CLABSI) Rate	**NHSN Definition-1/2016** (http://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf)
	
	Episodes of CLABSI in CVL X 1000
	Total number of central line days
	
	Blood Stream infection must meet one of the following criteria:
	1. Patient has a pathogen (not a common commensal) cultured from one or more blood cultures and organism cultured is not related to infection at another site.
	2. Patient has a common commensal cultured from the blood culture (See note below)
	  a. Patient has at least one of the following signs and symptoms: fever (>38C or > 100.4F), chills, or hypotension.
	   AND
	  b. Positive laboratory results and signs and symptoms are not related to an infection at another site.
	   AND
	  c. Common skin contaminant is cultured from two or more blood cultures drawn on separate occasions.
	
	NOTE:
	* Cultures positive with "common commensals" must be identified in at least one bottle of each set to be worked up as a CLABSI
	* Catheter tip cultures are not used to determine whether a patient has a primary BSI.
	* Lines can be removed without blood culture based on site inflammation.
	
	Line days: *Day of admission or insertion is Day 1
	*Patients with 1 or more central lines will be counted as 1 line-day per hospital day. Line days should be counted at the same time of the day, 7 days per week.
	Risk factor is line-days, not days of a given line.
	
	Inclusion
	Numerator: Episodes of bacteremia as described above, in presence of a Central Line (An Intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood or hemodynamic monitoring.)
	
	Denominator: All non-midline catheters including non-tunneled (non-cuffed/temporary) or surgically-placed (cuffed/permanent catheters.
		HD = 1.61/1000 line days
		
		Comparative Reference:
		NHSN 2013 =
		• ICU: 1.3
		• Adult Ward: 0.90

	Exclusion Numerator: Automatic exclusion if occurs within 3 calendar days before admission, date of admission and 3 calendar days after admission. Blood cultures drawn after the date of the catheter removal are excluded. Denominator: Catheters that do not terminate at or above the superior vena cava (i.e. Midline Catheters) and Hemodialysis reliable outflow dialysis catheters (HeRO). **Present on Admission (POA)**: 2 calendar days prior to the date of admission, Hospital day 1 and Hospital day 2. Hospital day 3= HAI **Infection Window Period** (first positive diagnostic test, 3 days before and 3 days after). **Repeat Infection Timeframe (RIT)** - (14 day timeframe where date of event = day 1) If a RIT you must go back to the 1st event in NHSN and enter the new organism if the organism changed. PLEASE REFER TO THE CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTION (CLABSI) DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY	
KEY QUALITY INDICATOR	**FORMULA / DEFINITION**	**Target / Threshold / Comp Ref**
6. Central Line Utilization Ratio	$\dfrac{\text{Central Line Days}}{\text{Patient Days}}$ The Central Line Utilization Ratio is calculated by dividing the number of central line days by the number of patient days. Exclusion: Implanted ports are not counted as a central line day until it is accessed. Once accessed (even if flushed or used for blood draw) it is counted as a line day until discharged or the port is removed.	2015 Target: **HD = 0.58** Comparative Reference: NHSN 2013 = • ICU: 0.64 • Adult Ward: 0.59
7. Patient Satisfaction	Patient Satisfaction HCAHPS Discharge Survey questions: • #4 During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? • #14 During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? • #22 Would you recommend this hospital to your family and friends? **Percent "Top Box" Scores:** $\dfrac{\text{Total Top Responses}}{\text{Total Responses}}$ **X 100** *#4 Call Button "Top Box" response = "Always* *#14 Help With Pain "Top Box" response = "Always"* *#22 Would you Recommend "Top Box" response = "Definitely Yes"*	2015 Targets: HD = 65.82 HD = 81.91 HD = 77.79

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
8. Employee Turnover Rate	Total number of resignations/terminations $\times$ 100 Total number of monthly filled positions Numerator is a rolling 12 month # of terminations for full-time AND part-time employees Denominator - Average number of beginning active FT and PT employees for the last 12 months	2015 Target: **21%**
9. Patient Falls with Injury	Total number of falls with injury $\times$ 1000 Total number of patient days **Fall with injury:** Any fall resulting in injury and requiring more than first aid and an alteration in treatment. Includes falls with fractures, lacerations, changes in level of consciousness <u>due to the fall</u>. *Example* – Fall requiring an X-ray (positive for fracture) and surgical intervention. Note: *Does <u>not</u> include falls requiring first aid only or minor treatment* **CMS (QRP) Definition:** (Reporting begins April 1, 2016) CMS def. = bone fracture, joint dislodgement, closed head injury with altered consciousness, subdural hematoma.	Comparative Reference: **0.29 per 1000 pt. days** (Kindred HD Oct YTD, 2015)
10. Patient Falls without Injury	Total number of falls without injury $\times$ 1000 Total number of patent days **Fall without injury:** A fall where no change in treatment is required. *Example* – A patient has a fall with no lacerations, minor pain and negative x-ray. *Note:* A fall requiring basic first aid treatment (i.e., Band-Aid or ice pack) is considered a Level 2 fall <u>without</u> injury. *A patient assisted to the floor is considered a fall.* **CMS (QRP) Definition:** (Reporting begins April 1, 2016) CMS def. = superficial bruising, hematomas, sprains or any fall related injury that causes the patient to complain of pain.	Comparative Reference: **3.99 per 1000 pt. days** (Kindred HD Oct. YTD,2015)
11. Restraint Rate	Number of patients each day in restraints, during the month $\times$ 1000 Total number of patient days • Restraint days are determined by the number of patients reported in restraints for <u>any</u> part of the prior 24 hours. • Four side rails, Freedom Splints and mitts (tied or untied), Fingerless positioning devices/mitts **are** counted as a restraint • Patients in restraints will be identified through direct observation rather than chart review.	2015 Target: HD = 65.2

12. Catheter – Associated Urinary Tract Infection (CAUTI) Rate	NHSN Definition 1/2016 (http://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf)	2015 Target:

NHSN Definition 1/2016
(http://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf)

Number of patient episodes during the month which develop
<u>newly diagnosed urinary catheter associated UTI</u>   X 1000
Total number of indwelling catheter days for the month.

Symptomatic UTI (SUTI) 1A
Patient must meet 1, 2, and 3 below:
1. Patient has an indwelling urinary catheter **in place for the entire day on the date of event** and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1)
2. Patient has at least one of the following signs or symptoms:
    - • fever (>38.0°C or 100.4°F)
    - • suprapubic tenderness*
    - • costovertebral angle pain or tenderness*
    - • urinary urgency ^
    - • urinary frequency ^
    - • dysuria ^
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria of ≥10^5 CFU/ml. All elements of the UTI criterion must occur during the Infection Window Period (See Definition Chapter 2 Identifying HAIs in NHSN)

NOTE: ^ These symptoms cannot be used when a catheter is in place.
          * With no other recognized cause

Asymptomatic Bacteremic UTI (ABUTI)
Patient must meet 1, 2, and 3 below:
1. Patient with* or without an indwelling urinary catheter has no signs or symptoms of SUT1 according to age (**NOTE:** Patients > 65 years of age with a non-catheter associated ABUTI <u>may</u> have a fever and still meet the ABUTI Criterion)
2. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium of ≥10^5CFU/ml
3. Patient has organism identified** from blood specimen with at least one matching bacterium identified in the urine specimen.

NOTE: * Patient had an indwelling urinary catheter in place for > 2 calendar days, with day of device placement being Day 1, and catheter was in place on the date of the event or the day before.
          ** Organisms identified by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment.

Asymptomatic Bacteremic Urinary Tract Infection is not considered a CAUTI in patients *without* a urinary catheter.

Inclusion

2015 Target:

HD = 1.87 per 1000 catheter days

Comparative Reference:
NHSN 2013 =
- • ICU: 2.25
- • Adult Ward: 2.0

Numerator: Episodes of UTI as described above, in presence of
indwelling catheter (*see below)

Denominator: Indwelling urinary catheter days
Exclusion
Numerator: Positive Urine cultures that are positive only for yeast,
mold, dimorphic fungi, or parasites are excluded. If urine culture is
positive for those exclusions and there is positive blood culture then the
CLABSI definition should be followed. Patients who meet the Infection
Window Period of first diagnostic test, 3 calendar days before,
and 3 calendar days after. More than two microorganisms indicate a
dirty" / contaminated specimen and not an infection.

Denominator: Suprapubic catheters and nephrostomy tubes are not
included in this definition, only catheters that enter
through the urethra.

*NOTE:
Present on Admission (POA): 2 calendar days prior to the date of
admission, Hospital day 1 and Hospital day 2. Hospital day 3=HAI
Infection Window Period (first positive diagnostic test, 3 days before and
3 days after)
Repeat Infection Timeframe (RIT) - (14 day timeframe where date of
event = day 1) If a RIT you must go back to the 1st event in NHSN and
enter the new organism if the organism changed.
*PLEASE REFER TO THE CATHETER-ASSOCIATED URINARY TRACT
INFECTION DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY*

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
13. Urinary Catheter Utilization Ratio	Urinary Catheter Days Patient Days The Urinary Catheter Utilization Ratio is calculated by dividing the number of urinary catheter days by the number of patient days.	2015 Target: **HD = 0.40** Comparative Reference: NHSN 2013 = • ICU: 0-51 • Adult Ward: 0.43
14. Return to Acute Care within 30 Days of Admission (RTA-30 days)	Number of discharges in the month with Discharge disposition equals "Return to STAC" within 30 days of admission **X 100** Total number of discharges for the month	2015 Target: **HD = 8.31**
15. Finger Stick (FS) Blood Glucose	Total number of finger sticks resulting in Glucose measure between 80 and 180 mg/dl **X 100** Total number of finger sticks Percent of glucose measures between 80 and 180 mg/dl. This does not constitute "tight control" or even "normal", but rather physiologic for a sick patient where low glucose is higher risk than high glucose. **Method:** Finger sticks collected electronically now. No exceptions. We	2015 Target: **HD = 71.6%**

	accept that for a given patient, when glucoses are out of range, more repeat testing is ordered, at a frequency proportional to the number out of range, i.e., "keep checking until it is back in range."	
KEY QUALITY INDICATOR	**FORMULA / DEFINITION**	**Target / Threshold / Comp Ref**
16. Successful Intubations	$$\frac{\text{Number of "Successful" Intubations}}{\text{Total number of patients with intubation episodes}} \times 100$$ "Successful" is defined as within 3 attempts	**Baseline will be collected in 2016**
17. Multi-Drug Resistant Organisms (MDRO) LabID Reporting	Report the NHSN components MDRO and CDI Module for facility wide inpatient (FacWidIN) MDRO Laboratory Identification Events that are reported as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C-Diff). **MRSA:** All blood cultures positive for MRSA will be entered in the NHSN system regardless of when it was identified during the inpatient stay. Numerator: <u>Patient Events reported in the NHSN</u> Denominator: Patient Days Total Facility Wide and Total Number of Admissions **C-Diff:** All stool cultures positive for C-Diff will be entered in the NHSN system regardless of when it was identified during the inpatient stay. Numerator: <u>Patient Events reported in the NHSN</u> Denominator: Patient Days Total Facility Wide and Total Number of Admissions **NOTE:** Do Not enter more than one event in NHSN within a 14-day period.	**New for 2015. As of 12/2015 NHSN has not published data.**
KEY QUALITY INDICATOR	**FORMULA / DEFINITION**	**Target / Threshold / Comp Ref**
20. Healthcare Personnel Influenza	**NHSN Definition 08/2014** (http://www.cdc.gov/nhsn/pdfs/hps-manual/vaccination/hps-flu-vaccine-protocol.pdf) Influenza season is defined by NHSN as October 1st through March 31st or sooner if the vaccinations become available. Each hospital is required to enter a reporting for at least one month during the reporting period. Summary data required is total number of employees on payroll (full time, part-time and PRN employees are included) that worked at least one day during the defined influenza period. Inclusions: Also included are all physicians, licensed independent practitioners, advanced practice nurses, physician assistants, adult students/trainees and volunteers.	Incremental increase in compliance according to the Joint Commission and Healthy People 2020.

	Exclusions: All contract workers are excluded (JLL, Pharmerica, Rehab Care, etc). When answering the six (6) questions in the summary, questions 2-6 must equal question one (1). The formatted questions can be found in the link listed in this document. Annual Vaccination Survey is not required but highly recommended it be completed prior to entering you summary data.	
21. Clinical Index	Comprised of the 3 clinical measures: CLABSI, CAUTI and Restraint Rate. The individual rates are divided by their individual *base* rates to get the individual index. The individual indexes are **summed** to calculate the overall Clinical Index: Example: CLABSI = 1.64 divided by base rate of 2.33 = 0.70 Restraint = 65.00 divided by base rate of 70.00 = 0.93 CAUTI = 1.89 divided by base rate of 3.06 = 0.62 2.25 (sum) **Overall Clinical Index = 2.25** *NOTE: The base rates are standard across all facilities and do not change from year to year. Base rates were established in year 2010.*	2015 Target: **HD = 1.82**
22. Service Index	Comprised of 3 Patient Satisfaction HCAHPS discharge survey questions: #4 During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? #14 During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? #22 Would you recommend this hospital to your family and friends? The percentage of "top box" responses are **averaged** to calculate the overall Service Index: Example: Question #4 % Always = 85% Question #14 % Always = 90% Question #22 % Definitely Yes = 90% 88.33% (average) **Overall Service Index = 88.33%**	2015 Target: **HD = 75.20**
23. Patient Safety Index	Comprised of the 4 clinical measures: % Reposition Orders Executed, % Wound Dressing Completed, % Consistent Branden Scores and % Wound Education Completed The percentage scores are **averaged** to calculate the overall Patient	2016 is the initial year for this Index. Q4 2015 data results will help inform target.

	Safety Index.
	
	Example:
	
	  % Reposition Orders Executed = 82%
	  % Wound Dressing Completed = 75%
	  % Consistent Braden Scores = 93%
	  % Wound Education Completed = <u>95%</u>
	                       86.25% (average)
	Overall Patient Safety Index = 86.25%	

24. Reputation.com	Composite Score based on six components: Star Average, Volume, Recentness, Length, Spread, and Visibility. Reputation BSC Indicator Information.	2015 Target: **HD = 332**

Leadership Committee Indicators (not already listed in 1-24 above)

KEY QUALITY INDICATOR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Regulatory / Survey Activity	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Regulatory Plan of Correction Update	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Patient Satisfaction Survey Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Complaints / Grievances Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Contract Services Oversight	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Competency Evaluations	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Licensure Verifications	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Employee Satisfaction	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
KHAT Utilization	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Ethics Case Review Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Termination of Life Support	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Organ/Tissue Donation	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Occupational Incidents Analysis (Loss Prevention) & RCA trends	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Patient / Visitor Event Summary (related to EOC)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Safety Management	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Security Incidents Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Hazardous Materials/Waste Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Fire-Safety Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Medical Equipment Management Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Utility Systems Management Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
CEO Physical Environment Compliance Oversight Checklist Review	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Environmental Tour Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Patient Safety and Reliability Committee Indicators (not already listed in 1-24 above)		
KEY QUALITY INDICATOR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Code Blue Reviews / Outcomes	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Rapid Response Events / Outcomes	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Decannulation Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Consent to Treat Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Change of Condition Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Mortality Reviews	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Hospital Acquired Pressure Wound RCA Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Fall RCA Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Surgical Program / Invasive Procedures	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Critical Results-Read Back (General Tests & ABG Tests)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Critical Results-Timeliness of Reporting (General Lab and ABG)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Cross-Match / Transfusion Ratio	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Transfusion Appropriateness	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Infusion Timeliness	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Blood Bank Testing Log	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Blood Product Transfusion Paperwork	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
RCA completed on all suspected blood transfusion reactions	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Radiology Dashboard	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Event Reporting System Trends Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Restraint Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Sentinel Event/Near Misses/Sentinel Event Alerts Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
FMEA Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Value Driven Transitions Committee Indicators		
KEY QUALITY INDICATOR	**DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED**	**ADDITIONAL INFO**
Hospital Performance Opportunity Trend Report. 3 Indicators: a) ALOS; b) Stay type percentages; c) CMI	1) All Payer types to be reviewed; 2) HD Common Goal for Combined Medicare & Medicare Mgd ALOS of >=25 but may be additional specificity based on patient historical data of population types (ex: high volume complex, vent patients may result in anticipated avg LOS well over 25) 3) Hospital-Specific Goals and/or analysis of trends for all other indicators.	See Dashboard HELP document for examples
Care Management Barriers/Avoidable Delay Occurrences: 4 categories of "avoidable delay occurrences" collected and trended: a) physician-related;	1) All Payer types to be reviewed; 2) No HD or hospital-specific goals - but universal goal is to decrease trends/causes in all categories. 3) CMs to adhere to H-ML 10-020 policy when collecting, reporting and analyzing the data.	See Dashboard HELP document for examples

b) external causes; c) internal causes; d) patient/family-related. Also discuss trends with "barriers" identified through preadmission (barrier to admission) and/or daily flash meetings		

Clinical Coordination and Documentation Improvement:
6 categories:
a) Top 10 DRGs
b) Focus DRG Analysis
c) Tier Rates;
d) IDT Assessment Results (two metrics: "Role-Specific" and "IDT Overall Functioning" scores;
e) Physician Snap Shot Report;
f) Documentation Opportunity Trends
	1) All Payer types to be reviewed with additional report for Medicare Top DRGs and Tier Rates;
	2) Common hospital goals:
	  a. Reduce/eliminate presence of filter DRG in top 10; percent tier rate of ALL DRGs is hospital-specific with goal of continued increased trend;
	  b. Top 10 DRGs at highest tier;
	  c. IDT
		See Dashboard HELP document for examples

KEY QUALITY INDICATOR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Transition Disposition Rates and Analysis 8 categories: a) expiration; b) STAC (RTA); c) Acute Rehab; d) SNF/NH; e) Hospice; f) Home w/HH; g) Home w/o HH; h) Other	1) All payers; 2) Individual hospital goals for RTA rate	See Dashboard HELP document for examples
Denial Management Tracking: 2 categories: a) Reasons for denials; b) Trends in reviewer/payer types	Indicator Parameters: Informational only. Calculate denials by total denials received during the month in Payer category. Report PI plans on any medical necessity/auth/LOC denials and reasons.	See Dashboard HELP document for examples
Medical Necessity Reviews: 2 categories: a) Physician Advisor	1) All payers for PA referrals; 2) Medicare & Medicare Mgd patients for HCO review	See Dashboard HELP document for examples

	Referral Review; b) High Cost Outlier Oversight		

Case Management Quality Monitoring<u>:</u> 3 categories: a) Case Management Documentation Audit (Admission, Continued Stay, Discharge); b) Resource Utilization Trends/ Opportunities; c) Departmental PI Activities	Case Mgmt Proficiency parameters: Ensure "proficiency" rates (90% or higher), "acceptable" rates (80%-89%) and "unacceptable rates" (<80%) are discussed and action plans proposed as per policy; 2)Resource Utilization Trends/Opportunities - parameters to be hospital-specific; 3)Departmental PI Activities - focuses on process improvement initiatives specific to CM and/or CCDI functions within a hospital based on trends.	See Dashboard HELP document for examples
TJC/CMS/State Regulatory updates/changes related to Utilization Management	Indicator Parameters: Awareness for updates that require compliance/monitoring	See Dashboard HELP document for examples

KEY QUALITY INDICATOR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Consultation Summary Report • Timeliness of Consultations • Timeliness of Consultation Reports	Summary Report of Consultation Reviews.	See Dashboard HELP document for examples
Medical Record Delinquencies Report Summary (Overall Delinquent Numbers / Percentage and Late H&Ps)	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. Data reported from monthly HIM statistics worksheet. H-IM 04-010A	See Dashboard HELP document for examples
Operative / Invasive Reports	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. H-IM 02-010	See Dashboard HELP document for examples
Order Entry and Usage - Verbal & Telephone Orders	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. See policies H-IM 02-020 (Concurrent Analysis of Orders) & H-IM 02-021 (Differentiation between Verbal and Written Orders). H-IM 02-021 PRO	See Dashboard HELP document for examples

| Order Entry and Usage - Verbal & Telephone Orders | Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. See policies H-IM 02-020 (Concurrent Analysis of Orders) & H-IM 02-021 (Differentiation between Verbal and Written Orders). H-IM 02-021 PRO | See Dashboard HELP document for examples |

Appendix C: Performance Improvement Tools

Item		Location
Annual Plans	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\ Annual Plan and Review ToolBox
Audit Tools	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Audit Tools
CCO Checklist	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\CEO-CCO Checklists\CCO Checklist
CEO Checklist	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\ Quality Management\ CEO-CCO Checklists\CEO Checklist
Dashboard training webinars	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Committee Standardization\2016 Dashboard Training Sessions
HVA Form	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Physical Environment\Emergency Management\Standardized Emergency Management Tools
ISMP Newsletters	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Pharmacy – Medication Mgmt\Medication Safety
PIT Documentation Template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation
PIT Commission / Charter	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation

Template		
PIT Prioritization Grid	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Quality Council\PIT Documentation
PIT Progress Report Template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation
QC Evaluation Form	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\AnnualPlanandReviewToolBox\Strategic Quality Plan
RCA Form	Policy	Policy H-PC 05-002C
IDT Evaluation Form	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\IDT\Master IDT Assessment Tool
IDT Quality Crosswalk	CRL	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\IDT Crosswalk
Tracers	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Tracers
Trend line chart template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Committee Standardization\Departmental PI Forms

APPENDIX D: Data Reporting Procedures

Data Reporting Procedures	Procedures
Reporting for Benchmark Report (BW) • Submission:	Benchmark data must be entered into the Data Entry Application in the Business Warehouse by the 8th of the month. After the 8th you will no longer have access to key your data. Contact Roxann Walker or Chastity Dailey at the Support Center if you are unable to key your data in order to receive further instructions. **TIPS WHEN SUBMITTING YOUR BENCHMARK DATA** 1. Once you have keyed your data, ALWAYS double check your numbers. 2. If you are a NON-ProTouch facility entering Wound Initial/Difference scores, make sure your numbers match your Wound Care Initiative Sheet.
• Corrections/Revisions	Requests to correct previously reported data must be submitted via e-mail addressed to either Chastity Dailey or Roxann Walker.

Patient Satisfaction Surveys	Our 3rd party vendor, Deyta Inc., must receive your surveys by the end of business on the 5th of every month in order to be credited to the previous month. For example: Feb surveys must be received at Deyta Inc.'s procesisng center by March 5th to be credited to February. All surveys received between Feb 6 and Mar 5 will be attributed to Feb. All surveys received between March 6 and April 5 will be attributed to March, etc. If the 5th falls on a weekend or holiday, surveys must be received at Deyta on the last open business day prior to the 5th. It is strongly recommended that you send completed surveys to Deyta Inc. on a weekly basis. If you send your surveys once monthly and miss the deadline, you will have 0 surveys posted for that month. Reports are available via the KNECT/Hospital Division/Dey Systems Reports link by the 12th of each month.
NHSN Reporting	Events are entered monthly. NHSN submits quarterly (120 days after the end of the quarter) to CMS. Each hospital is required to enter their monthly reporting plans, summary data related to CLABSI, CAUTI, VAE, MRSA Blood Lab ID and Clostridium difficile (C-Diff) LabID data and patient specific events in the NHSN website by the 8th of the following month. Following the submission of data the hospital should run the CMS reports in the NHSN website to validate that data has been reported. Healthcare Personnel (HCP) Influenza data is also entered each year by the May 15th reporting deadline in NHSN. HCP includes all staff including students, volunteers, physicians and allied health professionals that were employed or credentialed in the facility for 1 day during the October 1st to March 31st influenza reporting period. *This requirement does not include contract workers at this time.* Influenza reporting also requires that a survey be completed by each hospital annually when the annual summary is completed. Each year the facility is to complete the NHSN Annual Survey with hospital specific information in the NHSN website by the end of February the following year.
CMS CARE Data Submissions (Quality Reporting Program)	Admissions Assessments: CMS requires an **admission** CARE Data Set record to be submitted no later than the 15th calendar day of the patient's admission for all patients admitted to a Long Term Care Hospital (LTCH) regardless of payer type. Discharge Assessments: CMS requires a **discharge** CARE Data Set record to be submitted for all patients discharged from the LTCH no later than 13 days (discharge date counts as day 1) post discharge regardless of payer type. This includes discharge assessments for all discharge types: Planned, Unplanned and Expired.

	Interrupted Stays: For purposes of the QRP, an Interrupted Stay is when a patient is transferred to a short-term acute hospital and returns to the LTCH within 3 calendar days (discharge day is day 1). Patients that return after Day 4 must have a Discharge Assessment completed for the discharge to STAC and a new Admission CARE Assessment completed for the "new admission." Following submission of Admission and Discharge CARE Data Set Records, a CASPER Validation report must be retrieved from the CMS site and reviewed to ensure all records were Accepted. Accepted records are documented as such in the LTRAX database. Records not accepted must be corrected and resubmitted to CMS. The CASPER Validation report must be stored in the secure CMS CARE Data Set Documents folder located on the Kindred Network. Information on mapping to the secure CMS Care Data Set Documents folder can be found in the Clinical Resource Library (CRL/CMS/CMS Mandatory Quality Reporting/CARE Assessment Process).

APPENDIX E: Crosswalk of Quality Council Meetings (Medical Staff Bylaws to 2016 Strategic Quality Plan)

Bylaws Section	Medical Staff Committee	Meeting Frequency	Number of MS Members	2016 SQP Committee	Meeting Frequency	Comments/Action to be Taken
9.4	Medical Executive Committee (MEC)	Not specified but traditionally 10x per year. Rules & Regs silent.	Varies but typically 3-5 (Med. Dir., POMS, secy-Treasurer and any Med Dirs for specific services (ID, etc)	No change	At least quarterly	None needed unless local bylaws were amended to establish greater frequency
9.5	Credentialing Committee (if separate	Not specified; typically monthly. Ad	At least 3 (function may be	No change	Not specified	No change

	from MEC)	hoc meetings to approve appointments, reappointments are common	performed by MEC)			
9.6	Quality Council	*9.6.2-h reports at least quarterly to MEC* on overall quality, appropriateness and efficiency of medical care provided in the hospital, and on quality and resource management monitoring, review and evaluation and improvement activities; and 9.6.2-i report to the GB on a regular basis regarding the results of ongoing performance assessment and improvement activities. *9.6.3 QC meets at least 10x/year*	At least 1 (President of the Medical Staff)	No change	At least quarterly, but may meet more frequently as determined by the QC leadership	Delete 9.6.3
9.7	Ethics	Ethics policy says "quarterly or as outlined in Med Staff rules/regs."	2	Reports through Leadership	At least quarterly, more frequently as needed	No change
9.8	Operative and Other Invasive Procedures	9.8.2-e at least quarterly to QC	1-2	Reports through Patient Safety & Reliability	At least quarterly	No change
9.9	Blood Usage	9.9.2-d at least quarterly to QC	1-2	Reports through Patient Safety and Reliability	At least quarterly	No change
9.10	Medical	9.2.10-e at least	1-2	Reports	At least	No change

	Records	quarterly to QC		through Value-Driven Transitions	quarterly	
9.11	Medication Use, Nutrition, and Therapeutics	9.11.2-g at least quarterly to QC	At least 2	Reports through Patient Safety & Reliability	At least quarterly	No change
9.12	Infection Prevention	9.12.2-e at least quarterly to QC	At least 2	Reports through Patient Safety & Reliability	At least quarterly	No change
9.13	Utilization Review	9.13.2-d at least quarterly to QC	At least 2	Reports through Value-Driven Transitions	At least quarterly	No change
9.14	Clinical Laboratory	9.14.2-f at least quarterly	At least 1	Reports through Patient Safety & Reliability	At least quarterly	No change

Strategic Quality Operational Plan

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SECTION I

Commitment to Quality

Kindred's commitment to key quality indicators are aligned with and driven by our Mission, Vision, Values, Critical Success Factors, and our Management Philosophy. The Strategic Quality plan incorporates research and evidence from a variety of sources including the Institute for Healthcare Improvement (IHI), the Agency for Healthcare Research and Quality, the National Quality Forum and others.

Our Mission

Kindred Healthcare's mission is to promote healing, provide hope, preserve dignity and produce value for each patient, resident, family member, customer, employee and shareholder we serve.

Our Vision

Kindred Hospital Division's Vision is to be the hospital company of choice in the post-acute hospital setting and to provide a level of service and quality that is unequaled in the field.

Our Values

- Give your best
- Respect individuality to create team
- Be kinder than expected
- Do the right thing
- Treat others the way they want to be treated
- Create fun in all that you do
- Stay focused on the patient
- Take responsibility for every action you make

Critical Success Factors

- Manage Capital Wisely
- Be Efficient
- Grow
- Take Care of our People
- Organizational excellence through performance improvement
- Take care of our patients and customers

Kindred Management Philosophy

Focus on our people, on quality and customer service, and our business results will follow

Quality Aims

Our Strategic Quality Plan is the roadmap to excellence. The foundational underpinnings to Quality at Kindred are based on 5 Quality AIMS, adapted from the Institute of Medicine's (IOM) landmark report *Crossing the Quality Chasm*, the Institute for Healthcare Improvement's (IHI) Triple Aims, and Agency for Healthcare Research and Quality's (AHRQ) National Quality Strategy:

I. Patient Centered
II. Well Led
III. Safe and Reliable
IV. Smooth Transitions of care
V. Value Driven

Implementation of the Strategic Quality Plan is a strategy to mold the culture into one that values the Quality AIMS. Clinical programs, patient care processes and practices are evidence-based and focus on reducing variation and improving outcomes.

AIM I - Patient Centered Care

AIM One is an unwavering focus on patient's needs and expectations
- Care that is coordinated, informed and grounded in respectful interactions with care providers that are consistent with the patient's values, expectations and care decisions
- Care is efficient through appropriate use of resources at the least expense to the patient, provider and care setting
- Care is timely and provided without delay to mitigate any harm to a patient

Patient-centered care requires regular re-examination of the "Voice of the Customer" to gain ongoing feedback and insight about the effectiveness of processes critical to the patient.

AIM II - Safe, Reliable, Predictable and Regulatory Compliant

AIM Two is to provide care, which is safe, reliable and meets regulatory standards
- Delivery of care in a manner that minimizes the risk of harm to a patient
- Effective and reliable through use of evidence-based practices
- Ongoing compliance with regulatory and accreditation standards'
- Monitoring and Self-Assessment to ensure a continued state of survey readiness
- Compliance with mandatory reporting requirements

It is a core operational responsibility for every executive and every person providing and supporting care in our hospitals to ensure an environment where care is safe, effective and centered on patients' needs.

AIM III - Well-Led

AIM Three is to be well led with a bias towards action by clinical and operational leaders to achieve quality and safety objectives.

- Leaders set direction by aligning and coordinating strategic priorities and key initiatives
- Leaders build the foundation for execution by hiring, mentoring and retaining competent, quality-driven key leaders.
- Leaders who are quality driven effectively identifying issues, allocating resources, ensuring accountability and leading the execution of operational processes to maintain quality
- Leaders are visible conducting leadership rounding that ensures an understanding of needs, barriers and expectations of patients, families, and staff.

Leaders set expectations for continuous improvement by never being satisfied with anything less than the best.

AIM IV - Smooth Transitions of Care

AIM Four is to ensure smooth transitions of care during the hospital stay and to the next site of care. A standardized approach to key meetings ensures a safe, smooth and effective patient-centric approach during all transition of care **(Appendix D: Data Reporting Procedures)**

- Interdisciplinary Team (IDT) meetings ensure care planning begins upon admission and includes the development of discharge plans for each patient.
- IDT meetings are focused on "completing the care" to assure patients receive the right care at the right time and in the right place. The team utilizes a quality crosswalk **(see APPENDIX C for location of IDT Quality Crosswalk)** to ensure outcomes are viewed and discussed in "real time."
- Daily Transitions meetings track progress in order to maintain continuity of care and services needed to achieve treatment goals, eliminate barriers and facilitate the transition to the next level of care.

Identifying preventable delays that may prolong the hospital stay enhances patient satisfaction and continually creates patient value.

AIM V - Value-Driven

AIM Five is to provide care that is patient centered while adding patient value, conserving resources and avoiding waste.

- Resource utilization decisions, particularly in terms of additional new resources, should be evaluated as to the value added to the patient.
- Process improvement efforts work to eliminate non-value added steps hence improving performance and reducing cost.

- Hospital performance is compared to other hospitals within Kindred and external organizations or benchmarks, to achieve a best in class standard of excellence.

The leadership team must align all improvement activities with the strategic AIMS for the organization and identify gaps in activities and infrastructure that would be barriers to reaching goals.

- Clarify accountability for processes and outcomes throughout the organization
- Build the infrastructure for regular review and alignment of new and on-going initiatives, through data collection, analysis and reporting structures
- Create and publish a hospital-wide view of how key improvement activities and strategies throughout the organization align with strategic goals and aims. Make the Balanced Scorecard visible!
- Create reward and recognition systems for attainment of goals aligned with the strategic aims, assuring that the systems contribute to gain for the whole organization

SECTION II

Scope, Authority and Responsibilities

The Strategic Quality Plan provides the structure and processes for identifying, responding to, and implementing opportunities to fulfill our commitment to organizational excellence and the achievement of our Quality Aims. This quality plan is the central performance improvement plan in the organization and encompasses the inter-related functions and processes of clinical care, governance, operational and support services. Leaders foster performance improvement through planning, educating, setting priorities, providing appropriate time and resources and by constantly focusing on the primary tenets of the Strategic Quality Plans Quality Aims.

The Committee Structure is standardized to ensure consistent, transparent and effective implementation and oversight. The structured process:

- Facilitates a consistent unified structure to meet Strategic Quality Plan goals and objectives.
- Ensures an effective process for implementing the Hospital's QAPI program.
- Promotes transparent communication to the Quality Council, Medical Executive Committee and Governing Board.

The standardized Committee Structure, which includes standardized committee dashboards, provides a transparent method for data collection, aggregation, analysis and review of quality of care and safety concerns at the primary committee level. Utilization of the committee standardization process facilitates integration of quality and patient safety throughout the hospital through self-identification of issues, development of interdisciplinary action plans, to include physicians, and monitoring for rapid cycle improvement. The leadership of the facility, Quality Council, Medical Executive Committee, and Governing Board has the ultimate responsibility for monitoring and oversight of the effectiveness of the QAPI process. **(See Section VI)**

Governing Body

The ultimate responsibility for performance improvement rests with the Hospital Governing Board. The authority and responsibility for the day-to-day operations and performance improvement activity is delegated to the Hospital Quality Council and hospital leadership, including the leadership of the Medical Executive Committee.

Quality Council

The Hospital Quality Council is the central coordinating body for all performance improvement and patient safety activities within the hospital. The Quality Council meets regularly to ensure oversight of quality activities within the hospital. <u>The President of the Medical Staff (or designee) shall serve as Chairperson and the Chief Executive Officer shall serve as Vice-Chairperson.</u> Membership includes representation from both Medical Staff and various leadership positions; Medical Staff Members must be present (telephonically, if necessary).

The Quality Council coordinates the performance improvement process by:

- Establishing a planned, systematic, organization-wide approach to performance measurement, analysis and improvement.
- Utilizing Quality Council (QC) Committee structure that supports the implementation of the hospital-wide improvement process to include the following:
  - Planning the process of improvement activity to meet quality patient safety goals
  - Determining the scope and focus of measurement
  - Setting priories for improvement
  - Systematically measuring, analyzing and directing performance improvement
  - Implementing improvement activities based on assessment conclusions
  - Maintaining achieved improvements
- Standardized dashboards are utilized to ensure all performance improvement activities are reviewed in the appropriate QC Committee <u>prior to</u> review at Quality Council meetings. Committee configurations may vary according to size of facility, but standard dashboards covering established functions will be followed.
- Setting expectations for leadership and staff participation in interdisciplinary and interdepartmental performance improvement and patient safety activities.
- Allocating resources for the hospital's performance improvement and safety activities. Commissions/convenes performance improvement teams and approval of project selection for specific improvement efforts and monitors its progress.
- Ensuring that processes for identifying and managing serious and sentinel patient safety events are defined and implemented.
- Implementing and monitoring compliance with the National Patient Safety Goals (NPSG).
- Evaluating the effectiveness of the Strategic Quality Operational Plan and the effectiveness of leadership's contributions to performance improvement and patient safety at least annually. **(See Appendix C for location of Quality Council Evaluation)**

First Level Working Committees (also see Section VI)

First level working committees report to the Quality Council using specified dashboards with established meeting frequencies (minimum meeting frequency is quarterly). The first level working committees ensure substantive analysis of data and action planning occurs prior to review at Quality Council. These committees work to conduct data review and analysis as well as action planning and tracking and trending of action plans effectiveness on results.

This continuous flow of information and feedback ensures that quality of care and safety concerns are brought forth and addressed by the appropriate individuals and committees responsible for quality assurance and improvement activities.

The Medical Staff

The medical staff has a leadership role in organizational performance improvement and patient safety activities, particularly when a process is dependent primarily on the activities of individuals with clinical privileges. The Medical Staff Bylaws describe the expectations of members of the Medical Staff and allied health practitioners (AHPs) and their roles in quality improvement. The Medical Staff Rules and Regulations are expected to conform to the Medical Staff Bylaws.

The medical staff provides leadership in the areas of performance improvement and patient safety including though not limited to:
- Medical assessment and treatment of patients.
- Use of medications including safe ordering, transcription, dispensing and administration of medications.
- Outcomes related to resuscitative services
- Utilization of services and clinical products (i.e. operative and other procedure(s), blood products)
- Appropriateness and significant departures from established patterns of clinical practice
- Accurate, timely, and legible completion of patients' medical records
- Other activities as specified in the Medical Staff By-Laws

SECTION III

Quality Framework

Integrating Performance Improvement methodologies and tools is essential to a systematic approach to continuous process improvement. Continuous improvement is an ongoing effort to improve products, services or processes. These efforts can seek "incremental" improvement over time or "breakthrough" improvement all at once. **PDCA** is used to coordinate improvement efforts through emphasis on planning. The PDCA cycle goes from problem identification to implementation of the solution.

P: Plan, determine what the improvement will be and the method for data collection.
D: Do, implement the plan.
C: Check, review, and analyze the results.
A: Act, hold the gain and continue with the improvement

Act:
Keep the change or go back to planning.

PLAN the test of change via activities, actions, process steps (examples):
- Flowchart current processes.
- Determine the cause and effect of why you do what you do (to identify barriers).
- Flowchart a streamlined process removing waste or steps.

Check the results of the change:
- Find out from people involved what happened.
- Identify positives and negatives.
- Measure and compare before and after results.
- Is the result/outcome better?
- Was the defined goal met?

Do implement the change:
- Make sure all staff involved are aware of the plan.
- Make sure the Administrative team is on board and supportive of plan.

PDCA should be repeated for continuous improvement. If the solution does not improve the process, it is removed and the cycle is repeated with a different plan. If the solution does improve the process, it is standardized and the new process system knowledge is used to implement new improvements, beginning the cycle again.

Performance Improvement Teams (PIT) are convened when specific hospital-wide or interdepartmental issues are identified. The purpose of the PIT is to perform intensive analysis using a planned, systematic, organization-wide approach that facilitates designing, measuring, assessing and improving performance, using the PDCA methodology. Dependent upon the complexity of the process for improvement or design, other models may be selected such as process re-engineering, Rapid Cycle Improvement methods, etc.

Telling Your Quality Story through Data Visualization

Aggregation and analyses transform data into information that can be used to plan, change or monitor care. Performance is compared against industry standards, internal benchmarks, comparable external organizations and best practices in order to determine patterns and trends. Information from data analyses, process review and performance improvement efforts are used to make changes that improve performance, increase safety and reduce risk of a sentinel event occurring.

The utilization of statistical tools and methods in the analysis process is an expectation. Their use allows us to display data in different ways to uncover specific kinds of information, such as performance over time and performance depending on certain variables. When data is organized in a chart format, trends, patterns and relationships emerge. Charts give us a way to summarize large amounts of data at a quick glance. Different tools are designed for different purposes but all are generally designed to help us better understand our processes and the variation inherent in them. By understanding the type and cause of variation through the use of statistical tools and methods, the organization can focus its attention and resources on making improvements to the processes that will result in better outcomes.

The main goal of data visualization is to clearly and effectively communicate the information and performance through graphical means. When telling the story, the focus should be on providing visual analysis of data sets and communicating key aspects in an intuitive way. Example tools used to tell the story include:

Flow Charts: Flow charts show all steps in a process and give people a visual of the "big picture" so they see how each step is related to the next. Flow charts also help identify the most efficient way to complete a task or process:

Pareto Charts: Pareto charts are bar graphs that show in descending order how often a situation occurs. They identify consistent or frequent problems, and they help the team decide where to begin the improvement process.

Scatter Diagrams: Scatter diagrams show relationships between occurrences, situations, or actions. They allow the team to identify variables and the ways these variables affect the outcome.

Fishbone Diagrams: Fishbone diagrams are visuals used to show cause and effect. They help people explore what, when, and why therapy went wrong (or right).

Control Charts: Control charts, also known as Shewhart charts, are tools used to determine if a process is in a state of statistical control. Data are plotted in time order. It always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data.

<u>Trend lines</u>: A trend line visually identifies both trends and random variations in data. The more points used to draw the trend line, the more validity attached to the direction represented by the trend line.

SECTION IV

Using Outcomes to Drive Performance

Quality Assurance and Performance Improvement (QAPI) is a philosophy that encourages all members of a facility to identify new and better ways to do their job. The single best indicator of the effectiveness of the QAPI is the ability of a hospital to self-identify quality issues. Integrating self-assessment methodologies into everyday work processes makes for an efficient way to collect data and identify where systems are falling short, to make corrective adjustments, and to track outcomes.

The following Kindred processes are examples of concurrent *self-assessment* activities performed to evaluate compliance to regulatory and accreditation standards as well as key internal policies and procedures.

Examples of Self-Assessment Activities:

<u>Tracers</u>: Tracers are designed to "trace" the care experiences that a patient had while at Kindred or "trace" one specific process within the organization (i.e., complaint/grievance process). It is a way to analyze the system or process using actual patients as the framework for assessing compliance. While individual tracers follow a patient through his or her course of care, the system tracer evaluates the system or process, including the integration of related processes, and the coordination and communication among disciplines and departments in those processes. The results of tracers are used to formulate an action plan to address any identified deficiencies or issues.

<u>Leadership Rounding</u>: Rounding for outcomes is one of the skills used to better serve our patients, physicians and staff. Leaders round to build relationships, assess employee morale, harvest wins and identify and remove barriers that prevent staff from doing their jobs. Leadership rounding brings a different set of eyes and ears to the patient's bedside on a regular basis. As a result it presents an opportunity for service recovery, allows for gathering of information for staff reward and recognition, and helps connect leaders to our mission of serving patients.

<u>Complaint and Grievance Process</u>: A process to timely review, investigate, and resolve a patient's dissatisfaction. In addition to meeting regulatory requirements, a complaint and grievance process is an essential part of the quality program through identification of trends and patterns within the clinical and customer service program.

<u>Quality Assurance (QA)/Quality Control (QC) Audits</u>: QA audits may be a systematic review of care against explicit criteria (prevention of "defects"). QC audits are used to identify "defects" (temperatures, lab QCs, etc.). Departments use audits specific to their own PI goals. Regulatory audits may be specific to State and Federal expectations. The results of QA audits are often used to calculate rates for benchmark and other key performance indicators.

Quality and Regulatory Review (QRR) and Survey Readiness Visits (SRVs): The Division (through regional clinical operations and plant operations contract partners conducts formal onsite and offsite reviews to determine survey readiness in meeting The Joint Commission (TJC) accreditation standards and Centers for Medicare/Medicaid Services' (CMS) Hospital Conditions of Participation. QRRs rely heavily on patient and system tracers to evaluate the organization's potential performance during a survey.

Interdisciplinary Team (SQP/IDT crosswalk): The interdisciplinary team oversight and discussion of quality of care services, risk reduction and prevention opportunities, resource appropriateness and efficiency, and patient & family education allows for rapid cycle improvement opportunities. It also facilitates a concurrent review for accurate clinical documentation as a way to provide a clear story of each patient's care.

Flash/Daily Transitions/Care Plan Management Meetings: Daily Flash meeting is a CEO led interdisciplinary forum for daily evaluation of operations (e.g., staffing, patient change of conditions, equipment needs, plant issues, etc.). Daily Transitions meetings is a CCO led interdisciplinary forum for daily evaluation of 1) details related to timely follow up of patient care plan needs and 2) safe, organized transitions to next levels of care. These meetings allow for a concurrent evaluation of multiple performance indicators.

Failure Modes and Effects Analysis (FMEA): A proactive step-by-step approach for identifying all possible failures in a design, process, or a product or service. "Failure modes" means the ways, or modes, in which something might fail. Failures are any errors or defects, especially ones that affect the customer, and can be potential or actual.

Hazard Vulnerability Analysis (HVA): Provides a systematic approach to documenting potential threats that may affect demand for the hospitals services or its ability to provide those services. It is an essential component to a risk assessment, particularly related to emergency operations in a disaster.

Satisfaction Surveys: Patient, Employee and Physician feedback allow for identification of what your customers think is important, what they want, and where you need to improve. Patient safety culture surveys evaluate whether quality and safety are core values in the organization.

Annual Plans: This scheduled activity provides a consistent evaluation that highlights the achievements and continued challenges facing specific clinical programs such as Infection Prevention and Control, Risk Management, Environment of Care and Education.

Event/Error and Near Misses Analysis: Reporting of errors in a just culture environment allows individuals to report errors or near misses without fear of reprimand or punishment. This allows for identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior. Analysis with or without event calls can lead to identification of process change needs.

Clinical and Service Indices: A composite of several indicators into a single measure. Provides a quick self-assessment of several key division indicators.

<u>Mortality Review</u>: Review of patient deaths to evaluate clinical practice patterns and identify significant departure from established patterns of clinical practice.

Findings from the above (and other) self-assessment strategies trigger the performance improvement methodology used to drive change. The flow diagram depicted in Figure 1 is the typical process used. In summary, the process is such that self-assessment results are either evaluated by a department leader or DQM, and in collaboration with the CCO, who determine an appropriate PI project plan. If the results involve clinicians from more than a single department a decision is made to commission a PDCA project, either via a rapid cycle process or a more traditional Quality Council sanctioned Performance Improvement Team (PIT) project.

Rapid cycle is applying the recurring sequence of PDCA in a brief period of time to solve a problem or issue facing the team that will achieve breakthrough or continuous improvement results quickly.

If the results are to be reviewed and analyzed for committee recommended actions, Quality Council would commission and prioritize a formal PIT PDCA project. These QC sanctioned PIT projects typically include those improvements that are more organization-wide oriented (involves multiple departments), may require input from outside subject matter experts, and just generally command more time and human resources making the process slower and more methodical. Additionally, the Quality Council determines the prioritization of the performance improvement teams needed based on specific criteria. Performance Improvement Teams report progress and/or results through the Quality Council committee structure.

A PI project may begin as rapid cycle but evolve to a formal QC sanctioned PIT because of additional information obtained and a necessity to have more organizational level oversight.

Figure 1: PI Process

This same process is used when improvement opportunities are identified from external agencies (e.g., complaint survey, triennial accreditation survey, health department inspection). The goal, however, is to integrate an ample number of the right kind of self-assessments that provide a satisfactory sampling of current processes that are considered to be high risk, problem prone, low volume, etc.

See **Appendix C** for Location of Example PI Tools:

SECTION V

Quality Indicators

Quality indicators (or measures) are important as a way to document the outcomes of care, treatment and services provided and to identify opportunities for improvement. Kindred Hospitals annually determine the indicators it will use to measure performance as well as set corresponding goals. This process is done via one of two mechanisms:

a) Key Quality Indicators are those measures hard-wired on the agendas/dashboards of the first level working quality committees. These indicators are not optional and must be measured and reported on a frequency established by the quality committee (generally tracked monthly, reported quarterly). These indicators are often a condition of a regulatory or accreditation requirement but can also include items that are important to the patient population served.

   o A subsection of the key quality indicators are those core measures which all Kindred hospitals track with the expectation that the results will be compared to other Kindred Hospitals as well as national comparative benchmarks or databases. These key indicators are chosen as a result of an evidence-based look at the patient population served and are determined to have the greatest influence on outcomes of care.

   o Key quality indicators also include those areas that assess compliance with federally-mandated measures such as CMS' Quality Reporting Program (QRP) reporting requirements or IMPACT Act Requirements for 2018 (new/worsened PW).

   Key quality indicators are expected to be measured and reported despite level of compliance. Goals are set by the hospital unless the dashboard includes a goal or threshold that is expected to be used (Appendix B identifies the goals/thresholds set by the hospital and which are set as a common goal to be used by all hospitals).

b) Hospital-Specific Quality Indicators are chosen by the facility due to the significance related to one of its own key success factors, results of self-assessment activities, quality control processes, other high-risk high/low volume, problem-prone, or patient safety issues.

   o Department-specific performance indicators are chosen based on a process or system that department(s) want to improve.
   o Self-assessment activity findings may trigger a need to add an indicator to one of the first level working quality committee agendas in order to draw attention to an improvement needed. A rapid cycle PDCA or QC commissioned PIT PDCA project may be warranted.

- o Critical check list findings (CEO and CCO checklists) and quality control results may trigger a need to add an indicator to one of the first level working quality committee agendas in order to draw attention to an improvement needed. A rapid cycle PDCA or QC commissioned PIT PDCA project may be warranted. *Once sustained compliance is achieved data collection and reporting on that indicator may conclude. Goals or thresholds are set by the hospital.*
    - In the case of department-specific indicators, the indicator that has achieved sustained compliance should be replaced with another improvement indicator.
    - Self-assessment findings (including CEO & CCO checklists) or external agency deficiency findings that have been corrected with sustained compliance do not need to be replaced with another quality indicator.

Refer to the **Appendix B** for a complete library of Key Quality Indicators. Hospital-specific quality indicators can be added to the list locally or kept separately.

There are no specific requirements for a total number of indicators. A single indicator may fulfill the obligation for several categories (CLABSI is a key indicator on the Balanced Score Card, a CMS-QRP metric and meets the TJC requirement for monitoring infection control practices). Hospitals achieving desired performance targets, specifications or thresholds on hospital-specific measures may choose to change measures at any time, once performance levels are achieved and sustained.

Compliance to quality indicators is documented and presented to committee one of three ways:

1. Numeric Goal: A numeric goal includes a numerator and denominator. The numerator and denominator need to be explicit with regard to what is included or excluded in the measurement. For example, the numerator of mortality rate is total number of deaths for a month. The denominator is total number of discharges for that month. That definition must be followed exactly as written to ensure data validity. For example, changing the denominator to include only all non-hospice discharges would significantly change the result.

2. Summary Report: Those goals that are not numeric in nature are best evaluated through a summary report that demonstrates trends and patterns in outcomes achieved. For example, a Code Blue summary report allows for presentation of multiple elements included in that quality indicator. Some of the elements might be numeric, others might be non-numeric targets. The summary format allows for inclusion of key anecdotal notes, qualitative characteristics, and general observations, etc.

3. Existing Report: The Balanced Score Card and Benchmark Report are examples of static reports or queries available from the Business Warehouse (BW) that can be presented to a committee meeting as is. Analysis and action plans are added to these reports to demonstrate appropriate oversight and management of the data.

SECTION VI

Committee Structure

The Quality Council is the coordinating body for all hospital-wide quality assurance and performance improvement activities and processes. The Quality Council's Committee Structure supports implementation of the Quality Plan utilizing first level working quality committees with specified agendas, standardized dashboards and minimum meeting frequencies to ensure substantive analysis occurs prior to review at Quality Council. First level working committees report findings, analyses, recommendations, actions and follow up specific to the individual committee's functions.

Three first level working quality committees support the work of the Quality Council and cover all or parts of the following functions:
- Patient Safety and Reliability Committee
  - Pharmacy Nutrition and Therapeutics (PNT)
  - Infection Prevention and Control (IP&C)
  - Patient Care & Safety (including Critical Care, Operative & Invasive Procedures)
  - Laboratory / Radiology
- Leadership Committee
  - Leadership
  - Environment of Care (EOC)
  - Ethics
- Value Driven Transitions Committee
  - Utilization Management (UM)
  - Health Information Management (HIM)

Standardized Dashboards are utilized to help organize, track and trend key and hospital-specific quality indicators, monitoring activities and improvement efforts. Data are collected and reported on a frequency established by the first level committee (generally reviewed monthly and reported quarterly) to the designated first level committee. Subcommittees (often functional subcommittees such as PNT or HIM) may be designated to support the collection, aggregation, analyses and monitoring activities of a first level committee. Subcommittee summary forms are included in the Dashboard workbooks for documentation of subcommittee work that occurs between the quarterly first level committees. Hospital-specific quality indicators or performance improvement activities can be added to a specific dashboard at any time at the discretion of the hospital.

Credentialing activities may warrant more frequent meetings than quarterly to expedite applications and reapplications. The subcommittee summary form should be used to document discussions and recommendations between quarterly MEC meetings as well as for ad hoc (tele board) Governing Board approval activities.

When committee or monitoring findings fall outside of the parameters of expected or desired performance, an action plan is developed at the committee level. The PDCA process is utilized and clear responsibilities assigned. Proven strategies for prevention such as the Institute for Healthcare Improvement (IHI) Ventilator-Associated Pneumonia, Blood-Stream Infection and Catheter-Associated Urinary Tract Infection Bundles serve as the foundation for relevant improvement plans.

The Quality Council may determine additional actions or requirements are needed and redirect such actions to the working committees. Performance Improvement Teams may be convened by the Quality Council for significant and/or hospital-wide performance issues. Performance Improvement Teams will report progress and results to the Quality Council. The Quality Council will monitor compliance of the action plans and timelines as necessary.

This continuous flow of information and feedback encourages involvement from the individuals who are closest to the work and the committees they represent while having appropriate oversight by the leaders who are ultimately accountable for the quality assurance and improvement activities and program.

SECTION VII
Appendices

Appendix A: Terms / Definitions

Aggregate

A process for displaying data in a spreadsheet to provide results over time. Patterns and trends related to performance and/or compliance are identified and can then be analyzed.

Analysis

A process of interpretation and summarization of the data for a specific time period. The time frame may be determined based on the indicator or previous findings.

Clinical Quality Index

A composite of two or more indicators into a single metric used to measure performance in clinical care and outcomes.

Control Chart

A graphic display of data in the order they occur with statistically determined upper and lower control limits of expected common-cause variation.

Balanced Scorecard

Kindred Healthcare's key success factors scorecard. The indicators are reviewed with targets set on an annual basis.

Benchmark

A standard or point of reference against which things may be compared or assessed. Benchmarking is the process of comparing processes and performance metrics to best practices from other companies.

Benchmark Report

The title of one set of quality indicator data that is housed in Business Warehouse (such as Vent Admits, Vent Days, Restraint Days, CVL Days etc.).

Business Warehouse (BW)

Kindred Healthcare's Data Repository. Software that integrates, manages and stores data within the company from various data sources. Allows for business planning and analysis through data mining and visualization. Data entry is performed monthly for those elements that are not able to be compiled automatically.

CARE Data Set (Continuity Assessment Record and Evaluation)
A standardized patient assessment tool developed for use at acute hospital discharge and at post-acute care admission and discharge. The CARE Data Set is designed to standardize assessment of patients' medical, functional, cognitive, and social support status across acute and post-acute settings, including long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs).

Daily Flash Meeting
A CEO led interdisciplinary forum for daily evaluation of operations (e.g., staffing, patient change of conditions, equipment needs, plant issues, etc.).

Daily Transitions Meeting
A CCO led interdisciplinary forum for daily evaluation of 1) details related to timely follow up of patient care plan needs and 2) safe, organized transitions to next levels of care.

Dashboard
Standardized tools utilized throughout the quality council reporting structure to help organize, track and trend key and hospital-specific quality indicators, monitoring activities and improvement efforts.

Data
Un-interpreted material, facts, or clinical observations.

Failure Mode, Effects, and Analysis (FMEA)
A systematic approach for identifying the ways that a process can fail, the potential effects of such a failure and the seriousness of that effect, resulting in a process or system redesign to minimize the risk of failure.

GAP analysis
Comparison of actual performance with potential or desired performance.

IMPACT Act
On September 18, 2014, Congress passed the *Improving Medicare Post-Acute Care Transformation Act of 2014* (the IMPACT Act). The Act requires the submission of standardized patient assessment data related to quality measures, resource use, and other measures. The data elements are standardized across post-acute settings to facilitate coordinated care and improve Medicare beneficiary outcomes.

Indicator
A measure used to determine, over time, an organization's performance of functions, processes, and outcomes. Therapists rate patients' abilities to complete specific functional tasks as part of assessments in both LTAC and Nursing Centers.

Performance Improvement (PI)
The continuous study and adaptation of a health care organization's functions and processes to increase the probability of achieving desired outcomes and to better meet the needs of individuals and other users of services.

Performance Measure
A quantitative tool generally defined as regular measurement of outcome results which generates reliable data on effectiveness and efficiency of a specified process.

Patient Safety Index
A composite of two or more indicators into a single metric used to measure performance in areas important to Patient Safety.

Patient Satisfaction Index
A composite of two or more indicators into a single metric used to measure performance in customer service or satisfaction.

Plan of Correction (POC)
Specific, clearly defined steps or plans developed to eliminate identified root causes or implement new processes.

Quality Control (QC)
Quality control (QC) is a procedure or set of procedures intended to ensure that a product or performed service adheres to a defined set of quality criteria or meets the requirements of the customer. QC is similar, but not identical to, quality assurance (QA).

Quality Regulatory Review (QRR)
A hospital division program designed to determine survey readiness in meeting The Joint Commission (TJC) accreditation standards and Centers for Medicare/Medicaid Services' (CMS) conditions of Participation.

Quality Reporting Program (QRP)
The IMPACT Act of 2014 requires the specification of quality measures for the LTCH QRP, including such areas as skin integrity, functional status, such as mobility and self-care, as well as incidence of major falls. Beginning in FY 2014, the applicable annual update for any LTCH that did not submit the required data to CMS was reduced by two percentage points.

Root Cause Analysis
A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

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.

Tracer Methodology

A method used to "trace" a patient's care experience or a process using actual patients as the framework for assessing compliance. Individual Patient Tracers follow a patient through his or her course of care. System Tracers evaluate the systems or processes, including the integration of related processes, and the coordination and communication among disciplines and departments in those processes.

Appendix B: Key Quality Indicators Definitions, Formulas and Targets

(Target = Expected Goal, Threshold = Minimum Expectation, Comparative Reference = A reference to use for goal setting)

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
1. Mortality Rate	$$\frac{\text{Number of deaths}}{\text{Total number of discharges for month}} \times 100$$	Comparative Reference: **14.64%** (Kindred HD Oct. YTD 2015)
2. Wean Rate	Number of discharges for the month who were admitted* on a vent and were weaned for > 72 hours during the admission** **X 100** Total number of patients discharged who were admitted on the ventilator*** * Admitted on a vent = All patients admitted on a ventilator or placed on a ventilator within 7 days of admission. ** Only the 1st successful wean episode counts. *** As determined by daily vent charges that are dropped (use of drilldown on Benchmark report will indicate a 'N' for each patient that is excluded from the denominator (no vent charge) and a 'Y' for each patient that is included in the denominator (vent charge). For example, *BiPAP via vent* is not expected to count in the denominator yet since a vent is in use a charge may drop inadvertently adding this patient to the denominator count. In this case, incorrect charges must be corrected by the facility prior to the 8th of the month in order for Calculated Wean Rates to be correct Patients who are transferred out of our hospital for < 72 hours for a procedure/treatment at another hospital is not considered a discharge for the purposes of this indicator. **Please Note:** **Although the successful wean is "counted" at the time of discharge, it makes no difference if the patient is on or off the ventilator at the time of discharge. If the patient was successfully weaned (off the ventilator for > 72 hours) once during the admission, it counts as a wean. If a patient is subsequently placed back on the ventilator at any time during the admission, it will not be counted, in the numerator or the denominator, again.** **Inclusions** Numerator: Patients off vent >72 hours and placed on Trach collar or T-piece is a wean. **Exclusions** Numerator: Nocturnal vent is not a wean. Denominator: NIPPV is not a vent episode. Excludes all patients going on the vent > 7 days of admission. Weans that later die are successful weans. Ignore repeated episodes of ventilation. **NO exclusions for chronic vent admissions.** NOTE: Risk-adjusted outcome algorithms may vary slightly from above.	Comparative Reference: **49.19%** (Kindred HD Oct. YTD 2015)

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref

3. Infection-Related Ventilator-Associated Event (VAE)	**NHSN Definition-01/2016**
	(http://www.cdc.gov/nhsn/pdfs/pscmanual/10-vae_final.pdf)
	
	$\underline{\text{\# Episodes of IVAC in ventilated patient}}$ X 1000
	Total number Ventilator days
	Ventilator-Associated Condition (VAC)
	Patient has a baseline period of stability or improvement on the ventilator, defined by ≥ 2 calendar days of stable or decreasing daily minimum* FiO2 or PEEP values. The baseline period is defined as the 2 calendar days immediately Preceding the first day of increased daily minimum PEEP or FiO2.
	*Daily minimum defined by lowest value of FiO2 or PEEP during a calendar day that is maintained for **at least 1 hour**.
	After a period of stability or improvement on the ventilator, the patient has at least one of the following indicators of worsening oxygenation:
	  1) Minimum daily FiO2 values increase ≥ 0.20 (20 points) over baseline & remain at or above that increased level for ≥2 calendar days.
	  2) Minimum daily PEEP values increase ≥ 3 cmH2O over baseline and remain at or above that increased level for ≥2 calendar days.
	  NOTE: It is important to use the date the patient was placed on the ventilator when entering in NHSN. **DO NOT** use the date of admission unless that is the day the patient was intubated. If the patient comes to Kindred and you cannot get the date of first ventilation you can estimate the date.
	
	Infection-related Ventilator-Associated Complication (IVAC)
	On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, the patient meets <u>**both**</u> of the following criteria:
	  1) Temperature > 38 °C (100.4F) or < 36°C (96.8F), **OR** white blood cell (WBC) count ≥12,000 or ≤4,000 cells/mm3.
	  AND
	  2) A new antimicrobial agent(s) is started, and is continued for ≥ 4 calendar days.
	
	Possible Ventilator- Associated Pneumonia (PVAP) (Possible and Probable VAP combined)
	
	On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, ONE of the following criteria is met (taking into account organism exclusions specified in the protocol):
	
	□ **Criterion 1:** Positive culture of one of the following specimens, meeting quantitative or semi- quantitative thresholds as outlined in protocol, without requirement for purulent respiratory secretions:
	  • Endotracheal aspirate, ≥ 10^5 CFU/ml or corresponding semi-
		Comparative Reference: (Kindred HD Oct YTD, 2015)
		IVAC: 0.36 per 1000 ventilator days
		
		Comparative Reference: NHSN =
		As of 12/2015 NHSN has not published VAE data

quantitative result
- Bronchoalveolar lavage, ≥ 10^4 CFU/ml or corresponding semi-quantitative result
- Lung tissue, ≥ 10^4 CFU/g or corresponding semi-quantitative result
- Protected specimen brush, ≥ 10^3 CFU/ml or corresponding semi-quantitative result

□ **Criterion 2:** Purulent respiratory secretions (defined as secretions from the lungs, bronchi, or trachea that contain >25 neutrophils and <10 squamous epithelial cells per low power field [lpf, x100])† plus a positive culture of one of the following specimens (qualitative culture, or quantitative/semi-quantitative culture without sufficient growth to meet criterion #1):
- Sputum   • Endotracheal aspirate   • Bronchoalveolar lavage
- Lung tissue   • Protected specimen brush

† If the laboratory reports semi-quantitative results, those results must correspond to the above quantitative thresholds. See additional instructions for using the purulent respiratory secretions criterion in the VAE Protocol.

□ **Criterion 3:** One of the following positive tests:
- Pleural fluid culture (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube)
- Lung histopathology, defined as: 1) abscess formation or foci of consolidation with intense Neutrophil accumulation in bronchioles and alveoli; 2) evidence of lung parenchyma invasion by fungi (hyphae, pseudo hyphae or yeast forms); 3) evidence of infection with the viral pathogens listed below based on results of immunohistochemical assays, cytology, or microscopy performed on lung tissue
- Diagnostic test for Legionella species
- Diagnostic test on respiratory secretions for influenza virus, respiratory syncytial virus, adenovirus, parainfluenza virus, rhinovirus, human metapneumovirus, coronavirus

Inclusions:
    Patients on BiPAP via Tracheostomy
Exclusions:
    Skilled Nursing Units (SNU) and Subacute Units (SAU)

PLEASE REFER TO THE CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTION DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY or the **NHSN DEFINITIONS at:**
http://www.cdc.gov/nhsn/PDFs/pscManual/pcsManual_current.pdf

4. New or worsening	Patients with Pressure Ulcers That Are New or Worsened on Discharge CARE Assessments **X 100**	Comparative Reference: (2015 November YTD)

Pressure Ulcers	Number of Discharge CARE Assessments Measures "Percent of Patients with Pressure Ulcers that are New or Worsened" following CMS QRP reporting rules. Excludes expired patient discharge CARE Assessments.	Kindred HD = 2.08 LTRAX Nation = 1.81
KEY QUALITY INDICATOR	**FORMULA / DEFINITION**	**Target / Threshold / Comp Ref**

5. Central Line Associated Blood Stream Infection (CLABSI) Rate	**NHSN Definition-1/2016**
	(http://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf)
	
	<u>Episodes of CLABSI in CVL</u> **X 1000**
	Total number of central line days
	
	Blood Stream infection must meet one of the following criteria:
	  1. Patient has a pathogen (not a common commensal) cultured from one or more blood cultures and organism cultured is not related to infection at another site.
	  2. Patient has a common commensal cultured from the blood culture (See note below)
	    a. Patient has at least one of the following signs and symptoms: fever (>38C or > 100.4F), chills, or hypotension.
	    AND
	    b. Positive laboratory results and signs and symptoms are not related to an infection at another site.
	    AND
	    c. Common skin contaminant is cultured from two or more blood cultures drawn on separate occasions.
	
	NOTE:
	* Cultures positive with "common commensals" must be identified in at least one bottle of each set to be worked up as a CLABSI
	* Catheter tip cultures are not used to determine whether a patient has a primary BSI.
	* Lines can be removed without blood culture based on site inflammation.
	
	Line days: *Day of admission or insertion is Day 1
	*Patients with 1 or more central lines will be counted as 1 line-day per hospital day. Line days should be counted at the same time of the day, 7 days per week.
	*Risk factor is line-days, not days of a given line.
	
	Inclusion
	Numerator: Episodes of bacteremia as described above, in presence of a Central Line (An Intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood or hemodynamic monitoring.)
	
	Denominator: All non-midline catheters including non-tunneled (non-cuffed/temporary) or surgically-placed
		HD = 1.61/1000 line days
		
		Comparative Reference:
		NHSN 2013 =
		  • ICU: 1.3
		  • Adult Ward: 0.90

(cuffed/permanent catheters.

Exclusion
Numerator: Automatic exclusion if occurs within 3 calendar days before admission, date of admission and 3 calendar days after admission. Blood cultures drawn after the date of the catheter removal are excluded.

Denominator: Catheters that do not terminate at or above the superior vena cava (i.e. Midline Catheters) and Hemodialysis reliable outflow dialysis catheters (HeRO).

Present on Admission (POA): 2 calendar days prior to the date of admission, Hospital day 1 and Hospital day 2. Hospital day 3= HAI **Infection Window Period** (first positive diagnostic test, 3 days before and 3 days after).
Repeat Infection Timeframe (RIT) - (14 day timeframe where date of event = day 1) If a RIT you must go back to the 1st event in NHSN and enter the new organism if the organism changed.

PLEASE REFER TO THE CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTION (CLABSI) DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
6. Central Line Utilization Ratio	$$\frac{\text{Central Line Days}}{\text{Patient Days}}$$ The Central Line Utilization Ratio is calculated by dividing the number of central line days by the number of patient days. Exclusion: Implanted ports are not counted as a central line day until it is accessed. Once accessed (even if flushed or used for blood draw) it is counted as a line day until discharged or the port is removed.	2015 Target: **HD = 0.58** Comparative Reference: NHSN 2013 = • ICU: 0.64 • Adult Ward: 0.59
7. Patient Satisfaction	Patient Satisfaction HCAHPS Discharge Survey questions: • #4 During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? • #14 During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? • #22 Would you recommend this hospital to your family and friends? **Percent "Top Box" Scores:** $$\frac{\text{Total Top Responses}}{\text{Total Responses}} \text{ X 100}$$ *#4 Call Button "Top Box" response = "Always*	2015 Targets: **HD = 65.82** **HD = 81.91** **HD = 77.79**

	#14 Help With Pain "Top Box" response = "Always" #22 Would you Recommend "Top Box" response = "Definitely Yes"	
KEY QUALITY INDICATOR	**FORMULA / DEFINITION**	**Target / Threshold / Comp Ref**
8. Employee Turnover Rate	Total number of resignations/terminations **X 100** Total number of monthly filled positions Numerator is a rolling 12 month # of terminations for full-time AND part-time employees Denominator - Average number of beginning active FT and PT employees for the last 12 months	2015 Target: **21%**
9. Patient Falls with Injury	Total number of falls with injury **X 1000** Total number of patient days **Fall with injury:** Any fall resulting in injury and requiring more than first aid and an alteration in treatment. Includes falls with fractures, lacerations, changes in level of consciousness <u>due to the fall</u>. *Example –* Fall requiring an X-ray (positive for fracture) and surgical intervention. Note: *Does <u>not</u> include falls requiring first aid only or minor treatment* **CMS (QRP) Definition:** (Reporting begins April 1, 2016) CMS def. = bone fracture, joint dislodgement, closed head injury with altered consciousness, subdural hematoma.	Comparative Reference: **0.29 per 1000 pt. days** (Kindred HD Oct YTD, 2015)
10. Patient Falls without Injury	Total number of falls without injury **X 1000** Total number of patent days **Fall without injury:** A fall where no change in treatment is required. *Example –* A patient has a fall with no lacerations, minor pain and negative x-ray. *Note:* A fall requiring basic first aid treatment (i.e., Band-Aid or ice pack) is considered a Level 2 fall <u>without</u> injury. *A patient assisted to the floor is considered a fall.* **CMS (QRP) Definition:** (Reporting begins April 1, 2016) CMS def. = superficial bruising, hematomas, sprains or any fall related injury that causes the patient to complain of pain.	Comparative Reference: **3.99 per 1000 pt. days** (Kindred HD Oct. YTD,2015)

11. Restraint Rate	Number of patients each day in restraints, during the month **X 1000**
	        Total number of patient days
	
	 • Restraint days are determined by the number of patients reported in restraints for <u>any</u> part of the prior 24 hours.
	 • Four side rails, Freedom Splints and mitts (tied or untied), Fingerless positioning devices/mitts <u>are</u> counted as a restraint
	      • Patients in restraints will be identified through direct observation rather than chart review.
		2015 Target:
		
		 HD = 65.2

12. Catheter – Associated Urinary Tract Infection (CAUTI) Rate	**NHSN Definition 1/2016**
	(http://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf)
	
	  Number of patient episodes during the month which develop
	  <u>newly diagnosed urinary catheter associated UTI</u> **X 1000**
	  Total number of indwelling catheter days for the month.
	
	Symptomatic UTI (SUTI) 1A
	Patient must meet 1, 2, and 3 below:
	  1. Patient has an indwelling urinary catheter **in place for the entire day on the date of event** and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1)
	  2. Patient has at least one of the following signs or symptoms:
	    • fever (>38.0°C or 100.4°F)
	    • suprapubic tenderness*
	    • costovertebral angle pain or tenderness*
	    • urinary urgency ^
	    • urinary frequency ^
	    • dysuria ^
	  3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria of ≥10^5 CFU/ml. All elements of the UTI criterion must occur during the Infection Window Period (See Definition Chapter 2 Identifying HAIs in NHSN)
	NOTE: ^ These symptoms cannot be used when a catheter is in place.
	    * With no other recognized cause
	Asymptomatic Bacteremic UTI (ABUTI)
	Patient must meet 1, 2, and 3 below:
	  1. Patient with* or without an indwelling urinary catheter has no signs or symptoms of SUT1 according to age (**NOTE:** Patients > 65 years of age with a non-catheter associated ABUTI **may** have a fever and still meet the ABUTI Criterion)
	  2. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium of $\geq 10^5$ CFU/ml
	  3. Patient has organism identified** from blood specimen with at least one matching bacterium identified in the urine specimen.
	
	NOTE: * Patient had an indwelling urinary catheter in place for > 2 calendar days, with day of device placement being Day 1, and catheter was in place on the date of the event or the day before.
	    ** Organisms identified by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment.
	
	 Asymptomatic Bacteremic Urinary Tract Infection is not considered a CAUTI in patients *without* a urinary catheter.
		2015 Target:
		
		HD = 1.87 per 1000 catheter days
		
		Comparative Reference:
		NHSN 2013 =
		  • ICU: 2.25
		  • Adult Ward: 2.0

Inclusion
Numerator: Episodes of UTI as described above, in presence of indwelling catheter (*see below)

Denominator: Indwelling urinary catheter days
Exclusion
Numerator: Positive Urine cultures that are positive only for yeast, mold, dimorphic fungi, or parasites are excluded. If urine culture is positive for those exclusions and there is positive blood culture then the CLABSI definition should be followed. Patients who meet the Infection Window Period of first diagnostic test, 3 calendar days before,   and 3 calendar days after. More than two microorganisms indicate a dirty" / contaminated specimen and not an infection.

Denominator: Suprapubic catheters and nephrostomy tubes are not included in this definition, only catheters that enter through the urethra.

*NOTE:
Present on Admission (POA): 2 calendar days prior to the date of admission, Hospital day 1 and Hospital day 2. Hospital day 3=HAI
Infection Window Period (first positive diagnostic test, 3 days before and 3 days after)
Repeat Infection Timeframe (RIT) - (14 day timeframe where date of event = day 1) If a RIT you must go back to the 1st event in NHSN and enter the new organism if the organism changed.
PLEASE REFER TO THE CATHETER-ASSOCIATED URINARY TRACT INFECTION DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
13. Urinary Catheter Utilization Ratio	$\dfrac{\text{Urinary Catheter Days}}{\text{Patient Days}}$ The Urinary Catheter Utilization Ratio is calculated by dividing the number of urinary catheter days by the number of patient days.	2015 Target: **HD = 0.40** Comparative Reference: NHSN 2013 = • ICU: 0-51 • Adult Ward: 0.43
14. Return to Acute Care within 30 Days of Admission (RTA-30 days)	$\dfrac{\text{Number of discharges in the month with Discharge disposition equals "Return to STAC" within 30 days of admission}}{\text{Total number of discharges for the month}}$ **X 100**	2015 Target: **HD = 8.31**
15. Finger Stick (FS) Blood Glucose	$\dfrac{\text{Total number of finger sticks resulting in Glucose measure between 80 and 180 mg/dl}}{\text{Total number of finger sticks}}$ **X 100** Percent of glucose measures between 80 and 180 mg/dl. This does not	2015 Target: **HD = 71.6%**

	constitute "tight control" or even "normal", but rather physiologic for a sick patient where low glucose is higher risk than high glucose. **Method:** Finger sticks collected electronically now. No exceptions. We accept that for a given patient, when glucoses are out of range, more repeat testing is ordered, at a frequency proportional to the number out of range, i.e., "keep checking until it is back in range."	
KEY QUALITY INDICATOR	**FORMULA / DEFINITION**	**Target / Threshold / Comp Ref**
16. Successful Intubations	$$\frac{\text{Number of "Successful" Intubations}}{\text{Total number of patients with intubation episodes}} \times 100$$ "Successful" is defined as within 3 attempts	**Baseline will be collected in 2016**
17. Multi-Drug Resistant Organisms (MDRO) LabID Reporting	Report the NHSN components MDRO and CDI Module for facility wide inpatient (FacWidIN) MDRO Laboratory Identification Events that are reported as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C-Diff). **MRSA:** All blood cultures positive for MRSA will be entered in the NHSN system regardless of when it was identified during the inpatient stay. Numerator: Patient Events reported in the NHSN Denominator: Patient Days Total Facility Wide and Total Number of Admissions **C-Diff:** All stool cultures positive for C-Diff will be entered in the NHSN system regardless of when it was identified during the inpatient stay. Numerator: Patient Events reported in the NHSN Denominator: Patient Days Total Facility Wide and Total Number of Admissions **NOTE:** Do Not enter more than one event in NHSN within a 14-day period.	**New for 2015. As of 12/2015 NHSN has not published data.**
KEY QUALITY INDICATOR	**FORMULA / DEFINITION**	**Target / Threshold / Comp Ref**
20. Healthcare Personnel Influenza	**NHSN Definition 08/2014** **(http://www.cdc.gov/nhsn/pdfs/hps-manual/vaccination/hps-flu-vaccine-protocol.pdf)** Influenza season is defined by NHSN as October 1st through March 31st or sooner if the vaccinations become available. Each hospital is required to enter a reporting for at least one month during the reporting period. Summary data required is total number of employees on payroll (full time, part-time and PRN employees are included) that worked at least	Incremental increase in compliance according to the Joint Commission and Healthy People 2020.

	one day during the defined influenza period. Inclusions: Also included are all physicians, licensed independent practitioners, advanced practice nurses, physician assistants, adult students/trainees and volunteers. Exclusions: All contract workers are excluded (JLL, Pharmerica, Rehab Care, etc). When answering the six (6) questions in the summary, questions 2-6 must equal question one (1). The formatted questions can be found in the link listed in this document. Annual Vaccination Survey is not required but highly recommended it be completed prior to entering you summary data.	
21. Clinical Index	Comprised of the 3 clinical measures: CLABSI, CAUTI and Restraint Rate. The individual rates are divided by their individual *base* rates to get the individual index. The individual indexes are **summed** to calculate the overall Clinical Index: Example: CLABSI = 1.64 divided by base rate of 2.33 = 0.70 Restraint = 65.00 divided by base rate of 70.00 = 0.93 CAUTI = 1.89 divided by base rate of 3.06 = 0.62 2.25 (sum) **Overall Clinical Index = 2.25** *NOTE: The base rates are standard across all facilities and do not change from year to year. Base rates were established in year 2010.*	2015 Target: **HD = 1.82**
22. Service Index	Comprised of 3 Patient Satisfaction HCAHPS discharge survey questions: #4 During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? #14 During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? #22 Would you recommend this hospital to your family and friends? The percentage of "top box" responses are **averaged** to calculate the overall Service Index: Example: Question #4 % Always = 85% Question #14 % Always = 90% Question #22 % Definitely Yes = 90% 88.33% (average) **Overall Service Index = 88.33%**	2015 Target: **HD = 75.20**

23. Patient Safety Index	Comprised of the 4 clinical measures: % Reposition Orders Executed, % Wound Dressing Completed, % Consistent Branden Scores and % Wound Education Completed
	
	The percentage scores are **averaged** to calculate the overall Patient Safety Index.
	
	Example:
	
	    % Reposition Orders Executed = 82%
	    % Wound Dressing Completed = 75%
	    % Consistent Braden Scores = 93%
	    % Wound Education Completed = <u>95%</u>
	                    86.25% (average)
	Overall Patient Safety Index = 86.25%
		2016 is the initial year for this Index. Q4 2015 data results will help inform target.

24. Reputation.com	Composite Score based on six components: Star Average, Volume, Recentness, Length, Spread, and Visibility. Reputation BSC Indicator Information.	2015 Target: **HD = 332**

Leadership Committee Indicators (not already listed in 1-24 above)

KEY QUALITY INDICATOR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Regulatory / Survey Activity	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Regulatory Plan of Correction Update	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Patient Satisfaction Survey Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Complaints / Grievances Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Contract Services Oversight	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Competency Evaluations	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Licensure Verifications	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Employee Satisfaction	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
KHAT Utilization	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Ethics Case Review Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Termination of Life Support	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Organ/Tissue Donation	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Occupational Incidents Analysis (Loss Prevention) & RCA trends	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Patient / Visitor Event Summary (related to EOC)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Safety Management	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Security Incidents Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Hazardous Materials/Waste Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Fire-Safety Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Medical Equipment Management Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Utility Systems Management Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
CEO Physical Environment Compliance Oversight Checklist Review	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Environmental Tour Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Patient Safety and Reliability Committee Indicators *(not already listed in 1-24 above)*		
KEY QUALITY INDICATOR	**DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED**	**ADDITIONAL INFO**
Code Blue Reviews / Outcomes	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Rapid Response Events / Outcomes	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Decannulation Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Consent to Treat Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Change of Condition Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Mortality Reviews	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Hospital Acquired Pressure Wound RCA Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Fall RCA Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Surgical Program / Invasive Procedures	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Critical Results-Read Back (General Tests & ABG Tests)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Critical Results-Timeliness of Reporting (General Lab and ABG)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Cross-Match / Transfusion Ratio	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Transfusion Appropriateness	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Infusion Timeliness	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Blood Bank Testing Log	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Blood Product Transfusion Paperwork	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
RCA completed on all suspected blood transfusion reactions	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Radiology Dashboard	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Event Reporting System Trends Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Restraint Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Sentinel Event/Near Misses/Sentinel Event Alerts Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
FMEA Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Value Driven Transitions Committee Indicators		
KEY QUALITY INDICATOR	**DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED**	**ADDITIONAL INFO**
Hospital Performance Opportunity Trend Report. 3 Indicators: a) ALOS;	1) All Payer types to be reviewed; 2) HD Common Goal for Combined Medicare & Medicare Mgd ALOS of >=25 but may be additional specificity based on patient historical data of population types (ex: high volume complex, vent	See Dashboard HELP document for examples

b) Stay type percentages; c) CMI	patients may result in anticipated avg LOS well over 25) 3) Hospital-Specific Goals and/or analysis of trends for all other indicators.	
Care Management Barriers/Avoidable Delay Occurrences: 4 categories of "avoidable delay occurrences" collected and trended: a) physician-related; b) external causes; c) internal causes; d) patient/family-related. Also discuss trends with "barriers" identified through preadmission (barrier to admission) and/or daily flash meetings	1) All Payer types to be reviewed; 2) No HD or hospital-specific goals - but universal goal is to decrease trends/causes in all categories. 3) CMs to adhere to H-ML 10-020 policy when collecting, reporting and analyzing the data.	See Dashboard HELP document for examples

Clinical Coordination and Documentation Improvement:
6 categories:
a) Top 10 DRGs
b) Focus DRG Analysis
c) Tier Rates;
d) IDT Assessment Results (two metrics: "Role-Specific" and "IDT Overall Functioning" scores;
e) Physician Snap Shot Report;
f) Documentation Opportunity Trends
	1) All Payer types to be reviewed with additional report for Medicare Top DRGs and Tier Rates;
	2) Common hospital goals:
	  a. Reduce/eliminate presence of filter DRG in top 10; percent tier rate of ALL DRGs is hospital-specific with goal of continued increased trend;
	  b. Top 10 DRGs at highest tier;
	  c. IDT
		See Dashboard HELP document for examples

KEY QUALITY INDICATOR	**DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED**	**ADDITIONAL INFO**
Transition Disposition Rates and Analysis 8 categories: a) expiration; b) STAC (RTA); c) Acute Rehab; d) SNF/NH; e) Hospice; f) Home w/HH; g) Home w/o HH; h) Other	1) All payers; 2) Individual hospital goals for RTA rate	See Dashboard HELP document for examples

Denial Management Tracking: 2 categories: a) Reasons for denials; b) Trends in reviewer/payer types	Indicator Parameters: Informational only. Calculate denials by total denials received during the month in Payer category. Report PI plans on any medical necessity/auth/LOC denials and reasons.	See Dashboard HELP document for examples
Medical Necessity Reviews: 2 categories: a) Physician Advisor Referral Review; b) High Cost Outlier Oversight	1) All payers for PA referrals; 2) Medicare & Medicare Mgd patients for HCO review	See Dashboard HELP document for examples
Case Management Quality Monitoring: 3 categories: a) Case Management Documentation Audit (Admission, Continued Stay, Discharge); b) Resource Utilization Trends/ Opportunities; c) Departmental PI Activities	Case Mgmt Proficiency parameters: Ensure "proficiency" rates (90% or higher), "acceptable" rates (80%-89%) and "unacceptable rates" (<80%) are discussed and action plans proposed as per policy; 2)Resource Utilization Trends/Opportunities - parameters to be hospital-specific; 3)Departmental PI Activities - focuses on process improvement initiatives specific to CM and/or CCDI functions within a hospital based on trends.	See Dashboard HELP document for examples
TJC/CMS/State Regulatory updates/changes related to Utilization Management	Indicator Parameters: Awareness for updates that require compliance/monitoring	See Dashboard HELP document for examples
KEY QUALITY INDICATOR	**DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED**	**ADDITIONAL INFO**
Consultation Summary Report • Timeliness of Consultations • Timeliness of Consultation Reports	Summary Report of Consultation Reviews.	See Dashboard HELP document for examples
Medical Record Delinquencies Report Summary (Overall Delinquent Numbers / Percentage and Late H&Ps)	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. Data reported from monthly HIM statistics worksheet. H-IM 04-010A	See Dashboard HELP document for examples

Operative / Invasive Reports	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. H-IM 02-010	See Dashboard HELP document for examples
Order Entry and Usage - Verbal & Telephone Orders	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. See policies H-IM 02-020 (Concurrent Analysis of Orders) & H-IM 02-021 (Differentiation between Verbal and Written Orders). H-IM 02-021 PRO	See Dashboard HELP document for examples
Order Entry and Usage - Verbal & Telephone Orders	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. See policies H-IM 02-020 (Concurrent Analysis of Orders) & H-IM 02-021 (Differentiation between Verbal and Written Orders). H-IM 02-021 PRO	See Dashboard HELP document for examples

Appendix C: Performance Improvement Tools

Item		Location
Annual Plans	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\ Annual Plan and Review ToolBox
Audit Tools	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Audit Tools
CCO Checklist	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\CEO-CCO Checklists\CCO Checklist
CEO Checklist	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\ Quality Management\ CEO-CCO Checklists\CEO Checklist
Dashboard training	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Committee Standardization\2016 Dashboard Training Sessions

webinars		
HVA Form	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Physical Environment\Emergency Management\Standardized Emergency Management Tools
ISMP Newsletters	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Pharmacy – Medication Mgmt\Medication Safety
PIT Documentation Template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation
PIT Commission / Charter Template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation
PIT Prioritization Grid	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Quality Council\PIT Documentation
PIT Progress Report Template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation
QC Evaluation Form	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\AnnualPlanandReviewTool Box\Strategic Quality Plan
RCA Form	Policy	Policy H-PC 05-002C
IDT Evaluation Form	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\IDT\Master IDT Assessment Tool
IDT Quality Crosswalk	CRL	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\IDT Crosswalk
Tracers	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Tracers
Trend line chart template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Committee Standardization \Departmental PI Forms

APPENDIX D: Data Reporting Procedures

Data Reporting Procedures	Procedures
Reporting for Benchmark Report (BW) • Submission:	Benchmark data must be entered into the Data Entry Application in the Business Warehouse by the 8th of the month. After the 8th you will no longer have access to key your data. Contact Roxann Walker or Chastity Dailey at the Support Center if you are unable to key your data in order to receive further instructions.

• Corrections/Revisions	****TIPS WHEN SUBMITTING YOUR BENCHMARK DATA**** 1. **Once you have keyed your data, ALWAYS double check your numbers.** 2. **If you are a NON-ProTouch facility entering Wound Initial/Difference scores, make sure your numbers match your Wound Care Initiative Sheet.** Requests to correct previously reported data must be submitted via e-mail addressed to either Chastity Dailey or Roxann Walker.
Patient Satisfaction Surveys	Our 3rd party vendor, Deyta Inc., must receive your surveys by the end of business on the 5th of every month in order to be credited to the previous month. For example: Feb surveys must be received at Deyta Inc.'s procesisng center by March 5th to be credited to February. All surveys received between Feb 6 and Mar 5 will be attributed to Feb. All surveys received between March 6 and April 5 will be attributed to March, etc. If the 5th falls on a weekend or holiday, surveys must be received at Deyta on the last open business day prior to the 5th. It is strongly recommended that you send completed surveys to Deyta Inc. on a weekly basis. If you send your surveys once monthly and miss the deadline, you will have 0 surveys posted for that month. Reports are available via the KNECT/Hospital Division/Dey Systems Reports link by the 12th of each month.
NHSN Reporting	Events are entered monthly. NHSN submits quarterly (120 days after the end of the quarter) to CMS. Each hospital is required to enter their monthly reporting plans, summary data related to CLABSI, CAUTI, VAE, MRSA Blood Lab ID and Clostridium difficile (C-Diff) LabID data and patient specific events in the NHSN website by the 8th of the following month. Following the submission of data the hospital should run the CMS reports in the NHSN website to validate that data has been reported. Healthcare Personnel (HCP) Influenza data is also entered each year by the May 15th reporting deadline in NHSN. HCP includes all staff including students, volunteers, physicians and allied health professionals that were employed or credentialed in the facility for 1 day during the October 1st to March 31st influenza reporting period. *This requirement does not include contract workers at this time.* Influenza reporting also requires that a survey be completed by each hospital annually when the annual summary is completed. Each year the facility is to complete the NHSN Annual Survey with hospital specific information in the NHSN website by the end of February the following year.

CMS CARE Data Submissions *(Quality Reporting Program)*	Admissions Assessments: CMS requires an **admission** CARE Data Set record to be submitted no later than the 15th calendar day of the patient's admission for all patients admitted to a Long Term Care Hospital (LTCH) regardless of payer type. Discharge Assessments: CMS requires a **discharge** CARE Data Set record to be submitted for all patients discharged from the LTCH no later than 13 days (discharge date counts as day 1) post discharge regardless of payer type. This includes discharge assessments for all discharge types: Planned, Unplanned and Expired. Interrupted Stays: For purposes of the QRP, an Interrupted Stay is when a patient is transferred to a short-term acute hospital and returns to the LTCH within 3 calendar days (discharge day is day 1). Patients that return after Day 4 must have a Discharge Assessment completed for the discharge to STAC and a new Admission CARE Assessment completed for the "new admission." Following submission of Admission and Discharge CARE Data Set Records, a CASPER Validation report must be retrieved from the CMS site and reviewed to ensure all records were Accepted. Accepted records are documented as such in the LTRAX database. Records not accepted must be corrected and resubmitted to CMS. The CASPER Validation report must be stored in the secure CMS CARE Data Set Documents folder located on the Kindred Network. Information on mapping to the secure CMS Care Data Set Documents folder can be found in the Clinical Resource Library (CRL/CMS/CMS Mandatory Quality Reporting/CARE Assessment Process).

APPENDIX E: Crosswalk of Quality Council Meetings (Medical Staff Bylaws to 2016 Strategic Quality Plan)

Bylaws Section	Medical Staff Committee	Meeting Frequency	Number of MS Members	2016 SQP Committee	Meeting Frequency	Comments/Action to be Taken
9.4	Medical Executive Committee	Not specified but traditionally 10x per year.	Varies but typically 3-5 (Med.	No change	At least quarterly	None needed unless local bylaws were amended to

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	(MEC)	Rules & Regs silent.	Dir., POMS, secy-Treasurer and any Med Dirs for specific services (ID, etc)			establish greater frequency
9.5	Credentialing Committee (if separate from MEC)	Not specified; typically monthly. Ad hoc meetings to approve appointments, reappointments are common	At least 3 (function may be performed by MEC)	No change	Not specified	No change
9.6	Quality Council	**9.6.2-h reports at least quarterly to MEC** on overall quality, appropriateness and efficiency of medical care provided in the hospital, and on quality and resource management monitoring, review and evaluation and improvement activities; and 9.6.2-i report to the GB on a regular basis regarding the results of ongoing performance assessment and improvement activities. **9.6.3 QC meets at least 10x/year**	At least 1 (President of the Medical Staff)	No change	At least quarterly, but may meet more frequently as determined by the QC leadership	Delete 9.6.3
9.7	Ethics	Ethics policy	2	Reports	At least	No change

		says "quarterly or as outlined in Med Staff rules/regs."		through Leadership	quarterly, more frequently as needed	
9.8	Operative and Other Invasive Procedures	9.8.2-e at least quarterly to QC	1-2	Reports through Patient Safety & Reliability	At least quarterly	No change
9.9	Blood Usage	9.9.2-d at least quarterly to QC	1-2	Reports through Patient Safety and Reliability	At least quarterly	No change
9.10	Medical Records	9.2.10-e at least quarterly to QC	1-2	Reports through Value-Driven Transitions	At least quarterly	No change
9.11	Medication Use, Nutrition, and Therapeutics	9.11.2-g at least quarterly to QC	At least 2	Reports through Patient Safety & Reliability	At least quarterly	No change
9.12	Infection Prevention	9.12.2-e at least quarterly to QC	At least 2	Reports through Patient Safety & Reliability	At least quarterly	No change
9.13	Utilization Review	9.13.2-d at least quarterly to QC	At least 2	Reports through Value-Driven Transitions	At least quarterly	No change
9.14	Clinical Laboratory	9.14.2-f at least quarterly	At least 1	Reports through Patient Safety & Reliability	At least quarterly	No change

KINDRED HOSPITAL – YEAR
PATIENT SAFETY & RISK MANAGEMENT PLAN

Data Elements for Consideration	Hospital Specific Performance	Hospital Specific Goal	Area of Focus (X)
# Claims within last 12 months	Flamingo 2015 – 2 Sahara 2015 – 1 DeLima 2015 – 0 Market 2015 – 3	Las Vegas Market 2016 – 0	
Employee Turnover Rate YTD	Flamingo 2015 – 19.1 Sahara 2015 – 24.0 DeLima 2015 – 24.1	Flamingo 2016 – 18.0 Sahara 2016 – 18.5 DeLima 2016 – 18.8	
HAPU Rate YTD	Flamingo 2015 – 0.47 Sahara 2015 – 0.75 DeLima 2015 – 0.57 Market 2015 – 0.60	Las Vegas Market 2016 – 0.77	x
CLABSI Rate YTD	Flamingo 2015 – 0.73 Sahara 2015 – 1.82 DeLima 2015 – 1.09 Market 2015 – 1.22	Las Vegas Market 2016 – 1.61	x
CAUTI Rate YTD	Flamingo 2015 – 2.07 Sahara 2015 – 2.83 DeLima 2015 – 1.97 Market 2015 – 2.35	Las Vegas Market 2016 – 1.87	x
Workers Comp Claim/FTE	Flamingo 2015 – 6.5 Sahara 2015 – 9.0 DeLima 2015 – 7.5	Las Vegas Market 2016 – 4.0	
Employee Engagement Index Score	Flamingo 2015 – 4.07 Sahara 2015 – 3.93 DeLima 2015 – 3.93 Market 2015 – 4.08	Flamingo 2016 – 4.14 Sahara 2016 – 4.0 DeLima 2016 – 4.0 Market 2016 – 4.2	

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KINDRED HOSPITAL – YEAR
PATIENT SAFETY & RISK MANAGEMENT PLAN

Indicator		Las Vegas Market	
RTA Rate YTD	Flamingo 2015 – 14.1 Sahara 2015 – 14.7 DeLima 2015 – 8.63 Market 2015 – 13.18	Las Vegas Market 2016– 13.3	x
Customer Service Index	Flamingo 2015 – 92.35 Sahara 2015 – 88.37 DeLima 2015 – 84.57 Market 2015 – 89.49	Las Vegas Market 2016– 75.2	
Falls Rate YTD	Flamingo 2015 – 2.30 Sahara 2015 – 3.97 DeLima 2015 – 2.99 Market 2015 – 3.15	Las Vegas Market 2016– 3.99	x
Decannulations YTD	Flamingo 2015 – 1.66 Sahara 2015 – 1.29 DeLima 2015 – 0.93 Market 2015 – 1.39	Las Vegas Market 2016– 2.5	
Med Errors with Harm	Flamingo 2015 – 0 Sahara 2015 – 0 DeLima 2015 –3	Las Vegas Market 2016– 0	

Evaluate performance of above indicators, identify those that require focused attention on the right column; complete the action plan on the next page. Track action plan and progress throughout the year.

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Names in this page have been removed base on NRS439.843.

KINDRED HOSPITAL – YEAR
PATIENT SAFETY & RISK MANAGEMENT PLAN

Kindred Healthcare

Area of Focus	Plan	Responsible Party	Planned Completion Date

HAPU Rate YTD	1) Initiate PIT Team – Done at each facility
	  ➤ Sahara February 2015
	  ➤ Flamingo May 2015
	  ➤ DeLima October 2015
	2) Perform Mini RCA on all HAPU
	3) Have Wound Consultant Evaluate all HAPU for Staging Criteria
	4) Monitor all HAPU through Wound Tracking Tool
	5) Send Wound Tracking Tool to West Region Monthly
	6) Employ frontline staff in each Mini RCA
	7) Employ frontline staff in PIT Team
		Patient Safety and Reliability	September 1, 2016

CLABSI Rate YTD	1) Reconvene Task Force for Market 2) Conduct review of each CLABSI 3) Involve frontline Staff in review 4) Central Line Dressing Monitoring weekly for proper care and barrier assurance 5) BioPatch to conduct Point Prevalence Study 6) Continue monitoring of PICC Line Placement and adherence to technique 7) Use of Stat Caps with CHG start 1/2016	Reported through Patient Safety and Reliability	June 30, 2016
RTA Rate YTD	1) Continue Market PIT Team 2) Monitor RTA and Change in Internal Status 3) Perform Mini RCA on each RTA and Conduct Post Huddle for Improvements 4) Conduct Peer Review on unusual RTA data 5) Word on Physician Involvement in Recruiting necessary specialties to consult versus send out patients	Reported through Patient Safety and Reliability and Leadership	Ongoing - December 1, 2016
Falls Rate	1) Continue market Falls PIT 2) Monitor falls for rate and conduct Post Falls Assessments on all fall events 3) Improve Call Bell Response times 4) Conduct Hourly Rounding monitoring	Reported through Patient Safety and Reliability	July 1, 2016

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KINDRED HOSPITAL – YEAR
PATIENT SAFETY & RISK MANAGEMENT PLAN

	5) Set up No Pass Zones and keep staff accountable 6) Conduct education on scoring the Falls Score in Protouch. Individually educate changes in score that do not match patient assessment.		Ongoing - December 31, 2016
Customer Service	1. Addition of Patient Relations Representatives 2. Re-vitalize Leadership Rounding (ongoing) 3. Customization of Patient/Family Handbook for each campus and Welcome Packet 4. Implementation of Hourly rounding by staff (ongoing) 5. Servant Leadership and Culture of Service Program Training 6. Implemented new Meal Metrics to improve satisfaction with food Flamingo and Sahara with DeLima not participating due to contract) 7. Development of Patient/Family Advisory Council (Implement by 4th quarter 2016) 8. Participation in NHA Patient and Family Advisory Council Workgroup (every other month) 9. Revise Patient Safety handbook , complete by end of 3rd quarter 2016	Reported through Leadership Committee	

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Kindred Healthcare

KINDRED HOSPITAL-LAS VEGAS AT ST
ROSE DOMINICAN HOSPITAL
Strategic Quality Operational Plan

2016

H-ML 01-012

Strategic Quality Operational Plan

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SECTION I

Commitment to Quality

Kindred's commitment to key quality indicators are aligned with and driven by our Mission, Vision, Values, Critical Success Factors, and our Management Philosophy. The Strategic Quality plan incorporates research and evidence from a variety of sources including the Institute for Healthcare Improvement (IHI), the Agency for Healthcare Research and Quality, the National Quality Forum and others.

Our Mission

Kindred Healthcare's mission is to promote healing, provide hope, preserve dignity and produce value for each patient, resident, family member, customer, employee and shareholder we serve.

Our Vision

Kindred Hospital Division's Vision is to be the hospital company of choice in the post-acute hospital setting and to provide a level of service and quality that is unequaled in the field.

Our Values

- Give your best
- Respect individuality to create team
- Be kinder than expected
- Do the right thing
- Treat others the way they want to be treated
- Create fun in all that you do
- Stay focused on the patient
- Take responsibility for every action you make

Critical Success Factors

- Manage Capital Wisely
- Be Efficient
- Grow
- Take Care of our People
- Organizational excellence through performance improvement
- Take care of our patients and customers

Kindred Management Philosophy

Focus on our people, on quality and customer service, and our business results will follow

Quality Aims

Our Strategic Quality Plan is the roadmap to excellence. The foundational underpinnings to Quality at Kindred are based on 5 Quality AIMS, adapted from the Institute of Medicine's (IOM) landmark report *Crossing the Quality Chasm*, the Institute for Healthcare Improvement's (IHI) Triple Aims, and Agency for Healthcare Research and Quality's (AHRQ) National Quality Strategy:

I.   Patient Centered
II. Well Led
III. Safe and Reliable
IV. Smooth Transitions of care
V.   Value Driven

Implementation of the Strategic Quality Plan is a strategy to mold the culture into one that values the Quality AIMS. Clinical programs, patient care processes and practices are evidence-based and focus on reducing variation and improving outcomes.

AIM I - Patient Centered Care

AIM One is an unwavering focus on patient's needs and expectations
- Care that is coordinated, informed and grounded in respectful interactions with care providers that are consistent with the patient's values, expectations and care decisions
- Care is efficient through appropriate use of resources at the least expense to the patient, provider and care setting
- Care is timely and provided without delay to mitigate any harm to a patient

Patient-centered care requires regular re-examination of the "Voice of the Customer" to gain ongoing feedback and insight about the effectiveness of processes critical to the patient.

AIM II - Safe, Reliable, Predictable and Regulatory Compliant

AIM Two is to provide care, which is safe, reliable and meets regulatory standards
- Delivery of care in a manner that minimizes the risk of harm to a patient
- Effective and reliable through use of evidence-based practices
- Ongoing compliance with regulatory and accreditation standards'
- Monitoring and Self-Assessment to ensure a continued state of survey readiness
- Compliance with mandatory reporting requirements

It is a core operational responsibility for every executive and every person providing and supporting care in our hospitals to ensure an environment where care is safe, effective and centered on patients' needs.

AIM III - Well-Led

AIM Three is to be well led with a bias towards action by clinical and operational leaders to achieve quality and safety objectives.

- Leaders set direction by aligning and coordinating strategic priorities and key initiatives
- Leaders build the foundation for execution by hiring, mentoring and retaining competent, quality-driven key leaders.
- Leaders who are quality driven effectively identifying issues, allocating resources, ensuring accountability and leading the execution of operational processes to maintain quality
- Leaders are visible conducting leadership rounding that ensures an understanding of needs, barriers and expectations of patients, families, and staff.

Leaders set expectations for continuous improvement by never being satisfied with anything less than the best.

AIM IV - Smooth Transitions of Care

AIM Four is to ensure smooth transitions of care during the hospital stay and to the next site of care. A standardized approach to key meetings ensures a safe, smooth and effective patient-centric approach during all transition of care **(Appendix D: Data Reporting Procedures)**

- Interdisciplinary Team (IDT) meetings ensure care planning begins upon admission and includes the development of discharge plans for each patient.
- IDT meetings are focused on "completing the care" to assure patients receive the right care at the right time and in the right place. The team utilizes a quality crosswalk **(see APPENDIX C for location of IDT Quality Crosswalk)** to ensure outcomes are viewed and discussed in "real time."
- Daily Transitions meetings track progress in order to maintain continuity of care and services needed to achieve treatment goals, eliminate barriers and facilitate the transition to the next level of care.

Identifying preventable delays that may prolong the hospital stay enhances patient satisfaction and continually creates patient value.

AIM V - Value-Driven

AIM Five is to provide care that is patient centered while adding patient value, conserving resources and avoiding waste.

- Resource utilization decisions, particularly in terms of additional new resources, should be evaluated as to the value added to the patient.
- Process improvement efforts work to eliminate non-value added steps hence improving performance and reducing cost.

- Hospital performance is compared to other hospitals within Kindred and external organizations or benchmarks, to achieve a best in class standard of excellence.

The leadership team must align all improvement activities with the strategic AIMS for the organization and identify gaps in activities and infrastructure that would be barriers to reaching goals.

- Clarify accountability for processes and outcomes throughout the organization
- Build the infrastructure for regular review and alignment of new and on-going initiatives, through data collection, analysis and reporting structures
- Create and publish a hospital-wide view of how key improvement activities and strategies throughout the organization align with strategic goals and aims. Make the Balanced Scorecard visible!
- Create reward and recognition systems for attainment of goals aligned with the strategic aims, assuring that the systems contribute to gain for the whole organization

SECTION II

Scope, Authority and Responsibilities

The Strategic Quality Plan provides the structure and processes for identifying, responding to, and implementing opportunities to fulfill our commitment to organizational excellence and the achievement of our Quality Aims. This quality plan is the central performance improvement plan in the organization and encompasses the inter-related functions and processes of clinical care, governance, operational and support services. Leaders foster performance improvement through planning, educating, setting priorities, providing appropriate time and resources and by constantly focusing on the primary tenets of the Strategic Quality Plans Quality Aims.

The Committee Structure is standardized to ensure consistent, transparent and effective implementation and oversight. The structured process:

- Facilitates a consistent unified structure to meet Strategic Quality Plan goals and objectives.
- Ensures an effective process for implementing the Hospital's QAPI program.
- Promotes transparent communication to the Quality Council, Medical Executive Committee and Governing Board.

The standardized Committee Structure, which includes standardized committee dashboards, provides a transparent method for data collection, aggregation, analysis and review of quality of care and safety concerns at the primary committee level. Utilization of the committee standardization process facilitates integration of quality and patient safety throughout the hospital through self-identification of issues, development of interdisciplinary action plans, to include physicians, and monitoring for rapid cycle improvement. The leadership of the facility, Quality Council, Medical Executive Committee, and Governing Board has the ultimate responsibility for monitoring and oversight of the effectiveness of the QAPI process. **(See Section VI)**

Governing Body

The ultimate responsibility for performance improvement rests with the Hospital Governing Board. The authority and responsibility for the day-to-day operations and performance improvement activity is delegated to the Hospital Quality Council and hospital leadership, including the leadership of the Medical Executive Committee.

Quality Council

The Hospital Quality Council is the central coordinating body for all performance improvement and patient safety activities within the hospital. The Quality Council meets regularly to ensure oversight of quality activities within the hospital. <u>The President of the Medical Staff (or designee) shall serve as Chairperson and the Chief Executive Officer shall serve as Vice-Chairperson.</u> Membership includes representation from both Medical Staff and various leadership positions; Medical Staff Members must be present (telephonically, if necessary).

The Quality Council coordinates the performance improvement process by:

- Establishing a planned, systematic, organization-wide approach to performance measurement, analysis and improvement.
- Utilizing Quality Council (QC) Committee structure that supports the implementation of the hospital-wide improvement process to include the following:
  - ➤ Planning the process of improvement activity to meet quality patient safety goals
  - ➤ Determining the scope and focus of measurement
  - ➤ Setting priories for improvement
  - ➤ Systematically measuring, analyzing and directing performance improvement
  - ➤ Implementing improvement activities based on assessment conclusions
  - ➤ Maintaining achieved improvements
- Standardized dashboards are utilized to ensure all performance improvement activities are reviewed in the appropriate QC Committee <u>prior to</u> review at Quality Council meetings. Committee configurations may vary according to size of facility, but standard dashboards covering established functions will be followed.
- Setting expectations for leadership and staff participation in interdisciplinary and interdepartmental performance improvement and patient safety activities.
- Allocating resources for the hospital's performance improvement and safety activities. Commissions/convenes performance improvement teams and approval of project selection for specific improvement efforts and monitors its progress.
- Ensuring that processes for identifying and managing serious and sentinel patient safety events are defined and implemented.
- Implementing and monitoring compliance with the National Patient Safety Goals (NPSG).
- Evaluating the effectiveness of the Strategic Quality Operational Plan and the effectiveness of leadership's contributions to performance improvement and patient safety at least annually. **(See Appendix C for location of Quality Council Evaluation)**

First Level Working Committees (also see Section VI)

First level working committees report to the Quality Council using specified dashboards with established meeting frequencies (minimum meeting frequency is quarterly). The first level working committees ensure substantive analysis of data and action planning occurs prior to review at Quality Council. These committees work to conduct data review and analysis as well as action planning and tracking and trending of action plans effectiveness on results.

This continuous flow of information and feedback ensures that quality of care and safety concerns are brought forth and addressed by the appropriate individuals and committees responsible for quality assurance and improvement activities.

The Medical Staff

The medical staff has a leadership role in organizational performance improvement and patient safety activities, particularly when a process is dependent primarily on the activities of individuals with clinical privileges. The Medical Staff Bylaws describe the expectations of members of the Medical Staff and allied health practitioners (AHPs) and their roles in quality improvement. The Medical Staff Rules and Regulations are expected to conform to the Medical Staff Bylaws.

The medical staff provides leadership in the areas of performance improvement and patient safety including though not limited to:
- Medical assessment and treatment of patients.
- Use of medications including safe ordering, transcription, dispensing and administration of medications.
- Outcomes related to resuscitative services
- Utilization of services and clinical products (i.e. operative and other procedure(s), blood products)
- Appropriateness and significant departures from established patterns of clinical practice
- Accurate, timely, and legible completion of patients' medical records
- Other activities as specified in the Medical Staff By-Laws

SECTION III

Quality Framework

Integrating Performance Improvement methodologies and tools is essential to a systematic approach to continuous process improvement. Continuous improvement is an ongoing effort to improve products, services or processes. These efforts can seek "incremental" improvement over time or "breakthrough" improvement all at once. **PDCA** is used to coordinate improvement efforts through emphasis on planning. The PDCA cycle goes from problem identification to implementation of the solution.

P: Plan, determine what the improvement will be and the method for data collection.
D: Do, implement the plan.
C: Check, review, and analyze the results.
A: Act, hold the gain and continue with the improvement

Act:
Keep the change or go back to planning.

Check the results of the change:
- Find out from people involved what happened.
- Identify positives and negatives.
- Measure and compare before and after results.
- Is the result/outcome better?
- Was the defined goal met?

PLAN the test of change via activities, actions, process steps (examples):
- Flowchart current processes.
- Determine the cause and effect of why you do what you do (to identify barriers).
- Flowchart a streamlined process removing waste or steps.

Do implement the change:
- Make sure all staff involved are aware of the plan.
- Make sure the Administrative team is on board and supportive of plan.

PDCA should be repeated for continuous improvement. If the solution does not improve the process, it is removed and the cycle is repeated with a different plan. If the solution does improve the process, it is standardized and the new process system knowledge is used to implement new improvements, beginning the cycle again.

Performance Improvement Teams (PIT) are convened when specific hospital-wide or interdepartmental issues are identified. The purpose of the PIT is to perform intensive analysis using a planned, systematic, organization-wide approach that facilitates designing, measuring, assessing and improving performance, using the PDCA methodology. Dependent upon the complexity of the process for improvement or design, other models may be selected such as process re-engineering, Rapid Cycle Improvement methods, etc.

<u>Telling Your Quality Story through Data Visualization</u>

Aggregation and analyses transform data into information that can be used to plan, change or monitor care. Performance is compared against industry standards, internal benchmarks, comparable external organizations and best practices in order to determine patterns and trends. Information from data analyses, process review and performance improvement efforts are used to make changes that improve performance, increase safety and reduce risk of a sentinel event occurring.

The utilization of statistical tools and methods in the analysis process is an expectation. Their use allows us to display data in different ways to uncover specific kinds of information, such as performance over time and performance depending on certain variables. When data is organized in a chart format, trends, patterns and relationships emerge. Charts give us a way to summarize large amounts of data at a quick glance. Different tools are designed for different purposes but all are generally designed to help us better understand our processes and the variation inherent in them. By understanding the type and cause of variation through the use of statistical tools and methods, the organization can focus its attention and resources on making improvements to the processes that will result in better outcomes.

The main goal of data visualization is to clearly and effectively communicate the information and performance through graphical means. When telling the story, the focus should be on providing visual analysis of data sets and communicating key aspects in an intuitive way. Example tools used to tell the story include:

<u>Flow Charts</u>: Flow charts show all steps in a process and give people a visual of the "big picture" so they see how each step is related to the next. Flow charts also help identify the most efficient way to complete a task or process:

<u>Pareto Charts</u>: Pareto charts are bar graphs that show in descending order how often a situation occurs. They identify consistent or frequent problems, and they help the team decide where to begin the improvement process.

<u>Scatter Diagrams</u>: Scatter diagrams show relationships between occurrences, situations, or actions. They allow the team to identify variables and the ways these variables affect the outcome.

<u>Fishbone Diagrams</u>: Fishbone diagrams are visuals used to show cause and effect. They help people explore what, when, and why therapy went wrong (or right).

<u>Control Charts</u>: Control charts, also known as Shewhart charts, are tools used to determine if a process is in a state of statistical control. Data are plotted in time order. It always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data.

<u>Trend lines</u>: A trend line visually identifies both trends and random variations in data. The more points used to draw the trend line, the more validity attached to the direction represented by the trend line.

SECTION IV

Using Outcomes to Drive Performance

Quality Assurance and Performance Improvement (QAPI) is a philosophy that encourages all members of a facility to identify new and better ways to do their job. The single best indicator of the effectiveness of the QAPI is the ability of a hospital to self-identify quality issues. Integrating self-assessment methodologies into everyday work processes makes for an efficient way to collect data and identify where systems are falling short, to make corrective adjustments, and to track outcomes.

The following Kindred processes are examples of concurrent *self-assessment* activities performed to evaluate compliance to regulatory and accreditation standards as well as key internal policies and procedures.

Examples of Self-Assessment Activities:

<u>Tracers</u>: Tracers are designed to "trace" the care experiences that a patient had while at Kindred or "trace" one specific process within the organization (i.e., complaint/grievance process). It is a way to analyze the system or process using actual patients as the framework for assessing compliance. While individual tracers follow a patient through his or her course of care, the system tracer evaluates the system or process, including the integration of related processes, and the coordination and communication among disciplines and departments in those processes. The results of tracers are used to formulate an action plan to address any identified deficiencies or issues.

<u>Leadership Rounding</u>: Rounding for outcomes is one of the skills used to better serve our patients, physicians and staff. Leaders round to build relationships, assess employee morale, harvest wins and identify and remove barriers that prevent staff from doing their jobs. Leadership rounding brings a different set of eyes and ears to the patient's bedside on a regular basis. As a result it presents an opportunity for service recovery, allows for gathering of information for staff reward and recognition, and helps connect leaders to our mission of serving patients.

<u>Complaint and Grievance Process</u>: A process to timely review, investigate, and resolve a patient's dissatisfaction. In addition to meeting regulatory requirements, a complaint and grievance process is an essential part of the quality program through identification of trends and patterns within the clinical and customer service program.

<u>Quality Assurance (QA)/Quality Control (QC) Audits</u>: QA audits may be a systematic review of care against explicit criteria (prevention of "defects"). QC audits are used to identify "defects" (temperatures, lab QCs, etc.). Departments use audits specific to their own PI goals. Regulatory audits may be specific to State and Federal expectations. The results of QA audits are often used to calculate rates for benchmark and other key performance indicators.

Quality and Regulatory Review (QRR) and Survey Readiness Visits (SRVs): The Division (through regional clinical operations and plant operations contract partners conducts formal onsite and offsite reviews to determine survey readiness in meeting The Joint Commission (TJC) accreditation standards and Centers for Medicare/Medicaid Services' (CMS) Hospital Conditions of Participation. QRRs rely heavily on patient and system tracers to evaluate the organization's potential performance during a survey.

Interdisciplinary Team (SQP/IDT crosswalk): The interdisciplinary team oversight and discussion of quality of care services, risk reduction and prevention opportunities, resource appropriateness and efficiency, and patient & family education allows for rapid cycle improvement opportunities. It also facilitates a concurrent review for accurate clinical documentation as a way to provide a clear story of each patient's care.

Flash/Daily Transitions/Care Plan Management Meetings: Daily Flash meeting is a CEO led interdisciplinary forum for daily evaluation of operations (e.g., staffing, patient change of conditions, equipment needs, plant issues, etc.). Daily Transitions meetings is a CCO led interdisciplinary forum for daily evaluation of 1) details related to timely follow up of patient care plan needs and 2) safe, organized transitions to next levels of care. These meetings allow for a concurrent evaluation of multiple performance indicators.

Failure Modes and Effects Analysis (FMEA): A proactive step-by-step approach for identifying all possible failures in a design, process, or a product or service. "Failure modes" means the ways, or modes, in which something might fail. Failures are any errors or defects, especially ones that affect the customer, and can be potential or actual.

Hazard Vulnerability Analysis (HVA): Provides a systematic approach to documenting potential threats that may affect demand for the hospitals services or its ability to provide those services. It is an essential component to a risk assessment, particularly related to emergency operations in a disaster.

Satisfaction Surveys: Patient, Employee and Physician feedback allow for identification of what your customers think is important, what they want, and where you need to improve. Patient safety culture surveys evaluate whether quality and safety are core values in the organization.

Annual Plans: This scheduled activity provides a consistent evaluation that highlights the achievements and continued challenges facing specific clinical programs such as Infection Prevention and Control, Risk Management, Environment of Care and Education.

Event/Error and Near Misses Analysis: Reporting of errors in a just culture environment allows individuals to report errors or near misses without fear of reprimand or punishment. This allows for identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior. Analysis with or without event calls can lead to identification of process change needs.

Clinical and Service Indices: A composite of several indicators into a single measure. Provides a quick self-assessment of several key division indicators.

Mortality Review: Review of patient deaths to evaluate clinical practice patterns and identify significant departure from established patterns of clinical practice.

Findings from the above (and other) self-assessment strategies trigger the performance improvement methodology used to drive change. The flow diagram depicted in Figure 1 is the typical process used. In summary, the process is such that self-assessment results are either evaluated by a department leader or DQM, and in collaboration with the CCO, who determine an appropriate PI project plan. If the results involve clinicians from more than a single department a decision is made to commission a PDCA project, either via a rapid cycle process or a more traditional Quality Council sanctioned Performance Improvement Team (PIT) project.

Rapid cycle is applying the recurring sequence of PDCA in a brief period of time to solve a problem or issue facing the team that will achieve breakthrough or continuous improvement results quickly.

If the results are to be reviewed and analyzed for committee recommended actions, Quality Council would commission and prioritize a formal PIT PDCA project. These QC sanctioned PIT projects typically include those improvements that are more organization-wide oriented (involves multiple departments), may require input from outside subject matter experts, and just generally command more time and human resources making the process slower and more methodical. Additionally, the Quality Council determines the prioritization of the performance improvement teams needed based on specific criteria. Performance Improvement Teams report progress and/or results through the Quality Council committee structure.

A PI project may begin as rapid cycle but evolve to a formal QC sanctioned PIT because of additional information obtained and a necessity to have more organizational level oversight.

Figure 1: PI Process

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                    ┌─────────────────────┐
                    │   Findings from      │
                    │  Self-Assessment     │
                    │  activity compiled   │
                    └─────────────────────┘
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| Evaluated by department leader & DQM &/or CCO | Taken to appropriate lower level committee for recommended action |

| Departmental Specific PI Project | Rapid Cycle PDCA PI project via workgroup or task force | Performance Improvement Team (PIT) PDCA project commissioned & prioritized by Quality Council |

This same process is used when improvement opportunities are identified from external agencies (e.g., complaint survey, triennial accreditation survey, health department inspection). The goal, however, is to integrate an ample number of the right kind of self-assessments that provide a satisfactory sampling of current processes that are considered to be high risk, problem prone, low volume, etc.

See **Appendix C** for Location of Example PI Tools:

SECTION V

Quality Indicators

Quality indicators (or measures) are important as a way to document the outcomes of care, treatment and services provided and to identify opportunities for improvement. Kindred Hospitals annually determine the indicators it will use to measure performance as well as set corresponding goals. This process is done via one of two mechanisms:

a) Key Quality Indicators are those measures hard-wired on the agendas/dashboards of the first level working quality committees. These indicators are not optional and must be measured and reported on a frequency established by the quality committee (generally tracked monthly, reported quarterly). These indicators are often a condition of a regulatory or accreditation requirement but can also include items that are important to the patient population served.

   o A subsection of the key quality indicators are those core measures which all Kindred hospitals track with the expectation that the results will be compared to other Kindred Hospitals as well as national comparative benchmarks or databases. These key indicators are chosen as a result of an evidence-based look at the patient population served and are determined to have the greatest influence on outcomes of care.

   o Key quality indicators also include those areas that assess compliance with federally-mandated measures such as CMS' Quality Reporting Program (QRP) reporting requirements or IMPACT Act Requirements for 2018 (new/worsened PW).

   Key quality indicators are expected to be measured and reported despite level of compliance. Goals are set by the hospital unless the dashboard includes a goal or threshold that is expected to be used (Appendix B identifies the goals/thresholds set by the hospital and which are set as a common goal to be used by all hospitals).

b) Hospital-Specific Quality Indicators are chosen by the facility due to the significance related to one of its own key success factors, results of self-assessment activities, quality control processes, other high-risk high/low volume, problem-prone, or patient safety issues.

   o Department-specific performance indicators are chosen based on a process or system that department(s) want to improve.
   o Self-assessment activity findings may trigger a need to add an indicator to one of the first level working quality committee agendas in order to draw attention to an improvement needed. A rapid cycle PDCA or QC commissioned PIT PDCA project may be warranted.

- o Critical check list findings (CEO and CCO checklists) and quality control results may trigger a need to add an indicator to one of the first level working quality committee agendas in order to draw attention to an improvement needed. A rapid cycle PDCA or QC commissioned PIT PDCA project may be warranted.
  Once sustained compliance is achieved data collection and reporting on that indicator may conclude. Goals or thresholds are set by the hospital.
  - In the case of department-specific indicators, the indicator that has achieved sustained compliance should be replaced with another improvement indicator.
  - Self-assessment findings (including CEO & CCO checklists) or external agency deficiency findings that have been corrected with sustained compliance do not need to be replaced with another quality indicator.

Refer to the **Appendix B** for a complete library of Key Quality Indicators. Hospital-specific quality indicators can be added to the list locally or kept separately.

There are no specific requirements for a total number of indicators. A single indicator may fulfill the obligation for several categories (CLABSI is a key indicator on the Balanced Score Card, a CMS-QRP metric and meets the TJC requirement for monitoring infection control practices). Hospitals achieving desired performance targets, specifications or thresholds on hospital-specific measures may choose to change measures at any time, once performance levels are achieved and sustained.

Compliance to quality indicators is documented and presented to committee one of three ways:

1. Numeric Goal: A numeric goal includes a numerator and denominator. The numerator and denominator need to be explicit with regard to what is included or excluded in the measurement. For example, the numerator of mortality rate is total number of deaths for a month. The denominator is total number of discharges for that month. That definition must be followed exactly as written to ensure data validity. For example, changing the denominator to include only all non-hospice discharges would significantly change the result.

2. Summary Report: Those goals that are not numeric in nature are best evaluated through a summary report that demonstrates trends and patterns in outcomes achieved. For example, a Code Blue summary report allows for presentation of multiple elements included in that quality indicator. Some of the elements might be numeric, others might be non-numeric targets. The summary format allows for inclusion of key anecdotal notes, qualitative characteristics, and general observations, etc.

3. Existing Report: The Balanced Score Card and Benchmark Report are examples of static reports or queries available from the Business Warehouse (BW) that can be presented to a committee meeting as is. Analysis and action plans are added to these reports to demonstrate appropriate oversight and management of the data.

SECTION VI

Committee Structure

The Quality Council is the coordinating body for all hospital-wide quality assurance and performance improvement activities and processes. The Quality Council's Committee Structure supports implementation of the Quality Plan utilizing first level working quality committees with specified agendas, standardized dashboards and minimum meeting frequencies to ensure substantive analysis occurs prior to review at Quality Council. First level working committees report findings, analyses, recommendations, actions and follow up specific to the individual committee's functions.

Three first level working quality committees support the work of the Quality Council and cover all or parts of the following functions:
- Patient Safety and Reliability Committee
  - Pharmacy Nutrition and Therapeutics (PNT)
  - Infection Prevention and Control (IP&C)
  - Patient Care & Safety (including Critical Care, Operative & Invasive Procedures)
  - Laboratory / Radiology
- Leadership Committee
  - Leadership
  - Environment of Care (EOC)
  - Ethics
- Value Driven Transitions Committee
  - Utilization Management (UM)
  - Health Information Management (HIM)

Standardized Dashboards are utilized to help organize, track and trend key and hospital-specific quality indicators, monitoring activities and improvement efforts. Data are collected and reported on a frequency established by the first level committee (generally reviewed monthly and reported quarterly) to the designated first level committee. Subcommittees (often functional subcommittees such as PNT or HIM) may be designated to support the collection, aggregation, analyses and monitoring activities of a first level committee. Subcommittee summary forms are included in the Dashboard workbooks for documentation of subcommittee work that occurs between the quarterly first level committees. Hospital-specific quality indicators or performance improvement activities can be added to a specific dashboard at any time at the discretion of the hospital.

Credentialing activities may warrant more frequent meetings than quarterly to expedite applications and reapplications. The subcommittee summary form should be used to document discussions and recommendations between quarterly MEC meetings as well as for ad hoc (tele board) Governing Board approval activities.

When committee or monitoring findings fall outside of the parameters of expected or desired performance, an action plan is developed at the committee level. The PDCA process is utilized and clear responsibilities assigned. Proven strategies for prevention such as the Institute for Healthcare Improvement (IHI) Ventilator-Associated Pneumonia, Blood-Stream Infection and Catheter-Associated Urinary Tract Infection Bundles serve as the foundation for relevant improvement plans.

The Quality Council may determine additional actions or requirements are needed and redirect such actions to the working committees. Performance Improvement Teams may be convened by the Quality Council for significant and/or hospital-wide performance issues. Performance Improvement Teams will report progress and results to the Quality Council. The Quality Council will monitor compliance of the action plans and timelines as necessary.

This continuous flow of information and feedback encourages involvement from the individuals who are closest to the work and the committees they represent while having appropriate oversight by the leaders who are ultimately accountable for the quality assurance and improvement activities and program.

SECTION VII
Appendices

Appendix A: Terms / Definitions

Aggregate

A process for displaying data in a spreadsheet to provide results over time. Patterns and trends related to performance and/or compliance are identified and can then be analyzed.

Analysis

A process of interpretation and summarization of the data for a specific time period. The time frame may be determined based on the indicator or previous findings.

Clinical Quality Index

A composite of two or more indicators into a single metric used to measure performance in clinical care and outcomes.

Control Chart

A graphic display of data in the order they occur with statistically determined upper and lower control limits of expected common-cause variation.

Balanced Scorecard

Kindred Healthcare's key success factors scorecard. The indicators are reviewed with targets set on an annual basis.

Benchmark

A standard or point of reference against which things may be compared or assessed. Benchmarking is the process of comparing processes and performance metrics to best practices from other companies.

Benchmark Report

The title of one set of quality indicator data that is housed in Business Warehouse (such as Vent Admits, Vent Days, Restraint Days, CVL Days etc.).

Business Warehouse (BW)

Kindred Healthcare's Data Repository. Software that integrates, manages and stores data within the company from various data sources. Allows for business planning and analysis through data mining and visualization. Data entry is performed monthly for those elements that are not able to be compiled automatically.

CARE Data Set (Continuity Assessment Record and Evaluation)

A standardized patient assessment tool developed for use at acute hospital discharge and at post-acute care admission and discharge. The CARE Data Set is designed to standardize assessment of patients' medical, functional, cognitive, and social support status across acute and post-acute settings, including long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs).

Daily Flash Meeting

A CEO led interdisciplinary forum for daily evaluation of operations (e.g., staffing, patient change of conditions, equipment needs, plant issues, etc.).

Daily Transitions Meeting

A CCO led interdisciplinary forum for daily evaluation of 1) details related to timely follow up of patient care plan needs and 2) safe, organized transitions to next levels of care.

Dashboard

Standardized tools utilized throughout the quality council reporting structure to help organize, track and trend key and hospital-specific quality indicators, monitoring activities and improvement efforts.

Data

Un-interpreted material, facts, or clinical observations.

Failure Mode, Effects, and Analysis (FMEA)

A systematic approach for identifying the ways that a process can fail, the potential effects of such a failure and the seriousness of that effect, resulting in a process or system redesign to minimize the risk of failure.

GAP analysis

Comparison of actual performance with potential or desired performance.

IMPACT Act

On September 18, 2014, Congress passed the *Improving Medicare Post-Acute Care Transformation Act of 2014* (the IMPACT Act). The Act requires the submission of standardized patient assessment data related to quality measures, resource use, and other measures. The data elements are standardized across post-acute settings to facilitate coordinated care and improve Medicare beneficiary outcomes.

Indicator

A measure used to determine, over time, an organization's performance of functions, processes, and outcomes. Therapists rate patients' abilities to complete specific functional tasks as part of assessments in both LTAC and Nursing Centers.

Performance Improvement (PI)
The continuous study and adaptation of a health care organization's functions and processes to increase the probability of achieving desired outcomes and to better meet the needs of individuals and other users of services.

Performance Measure
A quantitative tool generally defined as regular measurement of outcome results which generates reliable data on effectiveness and efficiency of a specified process.

Patient Safety Index
A composite of two or more indicators into a single metric used to measure performance in areas important to Patient Safety.

Patient Satisfaction Index
A composite of two or more indicators into a single metric used to measure performance in customer service or satisfaction.

Plan of Correction (POC)
Specific, clearly defined steps or plans developed to eliminate identified root causes or implement new processes.

Quality Control (QC)
Quality control (QC) is a procedure or set of procedures intended to ensure that a product or performed service adheres to a defined set of quality criteria or meets the requirements of the customer. QC is similar, but not identical to, quality assurance (QA).

Quality Regulatory Review (QRR)
A hospital division program designed to determine survey readiness in meeting The Joint Commission (TJC) accreditation standards and Centers for Medicare/Medicaid Services' (CMS) conditions of Participation.

Quality Reporting Program (QRP)
The IMPACT Act of 2014 requires the specification of quality measures for the LTCH QRP, including such areas as skin integrity, functional status, such as mobility and self-care, as well as incidence of major falls. Beginning in FY 2014, the applicable annual update for any LTCH that did not submit the required data to CMS was reduced by two percentage points.

Root Cause Analysis
A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

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.

Tracer Methodology

A method used to "trace" a patient's care experience or a process using actual patients as the framework for assessing compliance. Individual Patient Tracers follow a patient through his or her course of care. System Tracers evaluate the systems or processes, including the integration of related processes, and the coordination and communication among disciplines and departments in those processes.

Appendix B: Key Quality Indicators Definitions, Formulas and Targets

(Target = Expected Goal, Threshold = Minimum Expectation, Comparative Reference = A reference to use for goal setting)

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
1. Mortality Rate	$$\frac{\text{Number of deaths}}{\text{Total number of discharges for month}} \times 100$$	Comparative Reference: **14.64%** (Kindred HD Oct. YTD 2015)
2. Wean Rate	$$\frac{\begin{array}{c}\text{Number of discharges for the month who were admitted* on a vent}\\ \text{and were weaned for > 72 hours during the admission**}\end{array}}{\begin{array}{c}\text{Total number of patients discharged who were admitted on the}\\ \text{ventilator***}\end{array}} \times 100$$ * Admitted on a vent = All patients admitted on a ventilator or placed on a ventilator within 7 days of admission. ** Only the 1st successful wean episode counts. *** As determined by daily vent charges that are dropped (use of drilldown on Benchmark report will indicate a 'N' for each patient that is excluded from the denominator (no vent charge) and a 'Y' for each patient that is included in the denominator (vent charge). For example, *BiPAP via vent* is not expected to count in the denominator yet since a vent is in use a charge may drop inadvertently adding this patient to the denominator count. In this case, incorrect charges must be corrected by the facility prior to the 8th of the month in order for Calculated Wean Rates to be correct Patients who are transferred out of our hospital for < 72 hours for a procedure/treatment at another hospital is not considered a discharge for the purposes of this indicator. **Please Note:** **Although the successful wean is "counted" at the time of discharge, it makes no difference if the patient is on or off the ventilator at the time of discharge. If the patient was successfully weaned (off the ventilator for > 72 hours) once during the admission, it counts as a wean. If a patient is subsequently placed back on the ventilator at any time during the admission, it will not be counted, in the numerator or the denominator, again.** **Inclusions** Numerator: Patients off vent >72 hours and placed on Trach collar or T-piece is a wean. **Exclusions** Numerator: Nocturnal vent is not a wean. Denominator: NIPPV is not a vent episode. Excludes all patients going on the vent > 7 days of admission. Weans that later die are successful weans. Ignore repeated episodes of ventilation. ***NO exclusions for chronic vent admissions.*** NOTE: Risk-adjusted outcome algorithms may vary slightly from above.	Comparative Reference: **49.19%** (Kindred HD Oct. YTD 2015)

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref

3. Infection-Related Ventilator-Associated Event (VAE)	**NHSN Definition-01/2016** **(http://www.cdc.gov/nhsn/pdfs/pscmanual/10-vae_final.pdf)**
	
	$\underline{\text{# Episodes of IVAC in ventilated patient}}$ X 1000
	         Total number Ventilator days
	Ventilator-Associated Condition (VAC)
	Patient has a baseline period of stability or improvement on the ventilator, defined by ≥ 2 calendar days of stable or decreasing daily minimum* FiO2 or PEEP values. The baseline period is defined as the 2 calendar days immediately Preceding the first day of increased daily minimum PEEP or FiO2.
	*Daily minimum defined by lowest value of FiO2 or PEEP during a calendar day that is maintained for **at least 1 hour**.
	After a period of stability or improvement on the ventilator, the patient has at least one of the following indicators of worsening oxygenation:
	1) Minimum daily FiO2 values increase ≥ 0.20 (20 points) over baseline & remain at or above that increased level for ≥2 calendar days.
	2) Minimum daily PEEP values increase ≥ 3 cmH2O over baseline and remain at or above that increased level for ≥2 calendar days.
	NOTE: It is important to use the date the patient was placed on the ventilator when entering in NHSN. **DO NOT** use the date of admission unless that is the day the patient was intubated. If the patient comes to Kindred and you cannot get the date of first ventilation you can estimate the date.
	
	Infection-related Ventilator-Associated Complication (IVAC)
	On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, the patient meets **both** of the following criteria:
	1) Temperature > 38 °C (100.4F) or < 36°C (96.8F), **OR** white blood cell (WBC) count ≥12,000 or ≤4,000 cells/mm3.
	AND
	2) A new antimicrobial agent(s) is started, and is continued for ≥ 4 calendar days.
	
	Possible Ventilator- Associated Pneumonia (PVAP) (Possible and Probable VAP combined)
	
	On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, ONE of the following criteria is met (taking into account organism exclusions specified in the protocol):
	
	☐ **Criterion 1:** Positive culture of one of the following specimens, meeting quantitative or semi- quantitative thresholds as outlined in protocol, without requirement for purulent respiratory secretions:
	    • Endotracheal aspirate, ≥ 10^5 CFU/ml or corresponding semi-
		Comparative Reference: (Kindred HD Oct YTD, 2015)
		IVAC: 0.36 per 1000 ventilator days
		
		Comparative Reference: NHSN =
		As of 12/2015 NHSN has not published VAE data

quantitative result
- Bronchoalveolar lavage, ≥ 10^4 CFU/ml or corresponding semi-quantitative result
- Lung tissue, ≥ 10^4 CFU/g or corresponding semi-quantitative result
- Protected specimen brush, ≥ 10^3 CFU/ml or corresponding semi-quantitative result

☐ **Criterion 2:** Purulent respiratory secretions (defined as secretions from the lungs, bronchi, or trachea that contain >25 neutrophils and <10 squamous epithelial cells per low power field [lpf, x100])† plus a positive culture of one of the following specimens (qualitative culture, or quantitative/semi-quantitative culture without sufficient growth to meet criterion #1):
- Sputum   • Endotracheal aspirate   • Bronchoalveolar lavage
- Lung tissue   • Protected specimen brush

† If the laboratory reports semi-quantitative results, those results must correspond to the above quantitative thresholds. See additional instructions for using the purulent respiratory secretions criterion in the VAE Protocol.

☐ **Criterion 3:** One of the following positive tests:
- Pleural fluid culture (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube)
- Lung histopathology, defined as: 1) abscess formation or foci of consolidation with intense Neutrophil accumulation in bronchioles and alveoli; 2) evidence of lung parenchyma invasion by fungi (hyphae, pseudo hyphae or yeast forms); 3) evidence of infection with the viral pathogens listed below based on results of immunohistochemical assays, cytology, or microscopy performed on lung tissue
- Diagnostic test for Legionella species
- Diagnostic test on respiratory secretions for influenza virus, respiratory syncytial virus, adenovirus, parainfluenza virus, rhinovirus, human metapneumovirus, coronavirus

Inclusions:
   Patients on BiPAP via Tracheostomy
Exclusions:
   Skilled Nursing Units (SNU) and Subacute Units (SAU)

PLEASE REFER TO THE CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTION DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY or the **NHSN DEFINITIONS at:**
http://www.cdc.gov/nhsn/PDFs/pscManual/pcsManual_current.pdf

4. New or worsening	Patients with Pressure Ulcers That Are New or <u>Worsened on Discharge CARE Assessments</u> **X 100**	Comparative Reference: (2015 November YTD)

Pressure Ulcers	Number of Discharge CARE Assessments Measures "Percent of Patients with Pressure Ulcers that are New or Worsened" following CMS QRP reporting rules. Excludes expired patient discharge CARE Assessments.	Kindred HD = 2.08 LTRAX Nation = 1.81
KEY QUALITY INDICATOR	**FORMULA / DEFINITION**	**Target / Threshold / Comp Ref**

5. Central Line Associated Blood Stream Infection (CLABSI) Rate	**NHSN Definition-1/2016**
	(http://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf)
	
	Episodes of CLABSI in CVL ___ X 1000
	Total number of central line days
	
	Blood Stream infection must meet one of the following criteria:
	1. Patient has a pathogen (not a common commensal) cultured from one or more blood cultures and organism cultured is not related to infection at another site.
	2. Patient has a common commensal cultured from the blood culture (See note below)
	  a. Patient has at least one of the following signs and symptoms: fever (>38C or > 100.4F), chills, or hypotension. **AND**
	  b. Positive laboratory results and signs and symptoms are not related to an infection at another site. **AND**
	  c. Common skin contaminant is cultured from two or more blood cultures drawn on separate occasions.
	
	NOTE:
	* Cultures positive with "common commensals" must be identified in at least one bottle of each set to be worked up as a CLABSI
	* Catheter tip cultures are not used to determine whether a patient has a primary BSI.
	* Lines can be removed without blood culture based on site inflammation.
	
	Line days: *Day of admission or insertion is Day 1
	*Patients with 1 or more central lines will be counted as 1 line-day per hospital day. Line days should be counted at the same time of the day, 7 days per week.
	*Risk factor is line-days, not days of a given line.
	
	Inclusion
	Numerator: Episodes of bacteremia as described above, in presence of a Central Line (An Intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood or hemodynamic monitoring.)
	
	Denominator: All non-midline catheters including non-tunneled (non-cuffed/temporary) or surgically-placed
		HD = 1.61/1000 line days
		
		Comparative Reference:
		NHSN 2013 =
		• ICU: 1.3
		• Adult Ward: 0.90

	(cuffed/permanent catheters.	
	Exclusion Numerator: Automatic exclusion if occurs within 3 calendar days before admission, date of admission and 3 calendar days after admission. Blood cultures drawn after the date of the catheter removal are excluded. Denominator: Catheters that do not terminate at or above the superior vena cava (i.e. Midline Catheters) and Hemodialysis reliable outflow dialysis catheters (HeRO). **Present on Admission (POA)**: 2 calendar days prior to the date of admission, Hospital day 1 and Hospital day 2. Hospital day 3= HAI **Infection Window Period** (first positive diagnostic test, 3 days before and 3 days after). **Repeat Infection Timeframe (RIT)** - (14 day timeframe where date of event = day 1) If a RIT you must go back to the 1st event in NHSN and enter the new organism if the organism changed. PLEASE REFER TO THE CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTION (CLABSI) DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY	

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
6. Central Line Utilization Ratio	$$\frac{\text{Central Line Days}}{\text{Patient Days}}$$ The Central Line Utilization Ratio is calculated by dividing the number of central line days by the number of patient days. Exclusion: Implanted ports are not counted as a central line day until it is accessed. Once accessed (even if flushed or used for blood draw) it is counted as a line day until discharged or the port is removed.	2015 Target: **HD = 0.58** Comparative Reference: NHSN 2013 = • ICU: 0.64 • Adult Ward: 0.59
7. Patient Satisfaction	Patient Satisfaction HCAHPS Discharge Survey questions: • #4 During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? • #14 During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? • #22 Would you recommend this hospital to your family and friends? **Percent "Top Box" Scores:** $$\frac{\text{Total Top Responses}}{\text{Total Responses}} \; \text{X 100}$$ *#4 Call Button "Top Box" response = "Always*	2015 Targets: **HD = 65.82** **HD = 81.91** **HD = 77.79**

	#14 Help With Pain "Top Box" response = "Always" #22 Would you Recommend "Top Box" response = "Definitely Yes"	
KEY QUALITY INDICATOR	**FORMULA / DEFINITION**	**Target / Threshold / Comp Ref**
8. Employee Turnover Rate	Total number of resignations/terminations **X 100** Total number of monthly filled positions Numerator is a rolling 12 month # of terminations for full-time AND part-time employees Denominator - Average number of beginning active FT and PT employees for the last 12 months	2015 Target: **21%**
9. Patient Falls with Injury	Total number of falls with injury **X 1000** Total number of patient days **Fall with injury:** Any fall resulting in injury and requiring more than first aid and an alteration in treatment. Includes falls with fractures, lacerations, changes in level of consciousness <u>due to the fall</u>. *Example* – Fall requiring an X-ray (positive for fracture) and surgical intervention. Note: *Does <u>not</u> include falls requiring first aid only or minor treatment* **CMS (QRP) Definition:** (Reporting begins April 1, 2016) CMS def. = bone fracture, joint dislodgement, closed head injury with altered consciousness, subdural hematoma.	Comparative Reference: **0.29 per 1000 pt. days** (Kindred HD Oct YTD, 2015)
10. Patient Falls without Injury	Total number of falls without injury **X 1000** Total number of patent days **Fall without injury:** A fall where no change in treatment is required. *Example* – A patient has a fall with no lacerations, minor pain and negative x-ray. *Note:* A fall requiring basic first aid treatment (i.e., Band-Aid or ice pack) is considered a Level 2 fall <u>without</u> injury. *A patient assisted to the floor is considered a fall.* **CMS (QRP) Definition:** (Reporting begins April 1, 2016) CMS def. = superficial bruising, hematomas, sprains or any fall related injury that causes the patient to complain of pain.	Comparative Reference: **3.99 per 1000 pt. days** (Kindred HD Oct. YTD,2015)
11. Restraint Rate	Number of patients each day in restraints, during the month **X 1000** Total number of patient days • Restraint days are determined by the number of patients reported in restraints for <u>any</u> part of the prior 24 hours. • Four side rails, Freedom Splints and mitts (tied or untied), Fingerless positioning devices/mitts **are** counted as a restraint • Patients in restraints will be identified through direct observation rather than chart review.	2015 Target: **HD = 65.2**

| 12. Catheter – Associated Urinary Tract Infection (CAUTI) Rate | **NHSN Definition 1/2016** (http://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf)

Number of patient episodes during the month which develop <u>newly diagnosed urinary catheter associated UTI</u>   **X 1000**
Total number of indwelling catheter days for the month.

Symptomatic UTI (SUTI) 1A
Patient must meet 1, 2, and 3 below:
  1. Patient has an indwelling urinary catheter **in place for the entire day on the date of event** and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1)
  2. Patient has at least one of the following signs or symptoms:
     • fever (>38.0°C or 100.4°F)
     • suprapubic tenderness*
     • costovertebral angle pain or tenderness*
     • urinary urgency ^
     • urinary frequency ^
     • dysuria ^
  3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria of ≥10^5 CFU/ml. All elements of the UTI criterion must occur during the Infection Window Period (See Definition Chapter 2 Identifying HAIs in NHSN)
NOTE: ^ These symptoms cannot be used when a catheter is in place.
    * With no other recognized cause
Asymptomatic Bacteremic UTI (ABUTI)
Patient must meet 1, 2, and 3 below:
  1. Patient with* or without an indwelling urinary catheter has no signs or symptoms of SUT1 according to age (**NOTE:** Patients > 65 years of age with a non-catheter associated ABUTI **may** have a fever and still meet the ABUTI Criterion)
  2. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium of ≥10^5CFU/ml
  3. Patient has organism identified** from blood specimen with at least one matching bacterium identified in the urine specimen.

NOTE: * Patient had an indwelling urinary catheter in place for > 2 calendar days, with day of device placement being Day 1, and catheter was in place on the date of the event or the day before.
    ** Organisms identified by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment.

Asymptomatic Bacteremic Urinary Tract Infection is not considered a CAUTI in patients *without* a urinary catheter. | **2015 Target:**

HD = 1.87 per 1000 catheter days

Comparative Reference: NHSN 2013 =
  • ICU: 2.25
  • Adult Ward: 2.0 |

Inclusion
Numerator: Episodes of UTI as described above, in presence of indwelling catheter (*see below)

Denominator: Indwelling urinary catheter days
Exclusion
Numerator: Positive Urine cultures that are positive only for yeast, mold, dimorphic fungi, or parasites are excluded. If urine culture is positive for those exclusions and there is positive blood culture then the CLABSI definition should be followed. Patients who meet the Infection Window Period of first diagnostic test, 3 calendar days before, and 3 calendar days after. More than two microorganisms indicate a dirty" / contaminated specimen and not an infection.

Denominator: Suprapubic catheters and nephrostomy tubes are not included in this definition, only catheters that enter through the urethra.

*NOTE:
Present on Admission (POA): 2 calendar days prior to the date of admission, Hospital day 1 and Hospital day 2. Hospital day 3=HAI
Infection Window Period (first positive diagnostic test, 3 days before and 3 days after)
Repeat Infection Timeframe (RIT) - (14 day timeframe where date of event = day 1) If a RIT you must go back to the 1st event in NHSN and enter the new organism if the organism changed.
PLEASE REFER TO THE CATHETER-ASSOCIATED URINARY TRACT INFECTION DECISION TREE LOCATED IN THE CLNICAL RESOURCE LIBRARY

KEY QUALITY INDICATOR	FORMULA / DEFINITION	Target / Threshold / Comp Ref
13. Urinary Catheter Utilization Ratio	$\dfrac{\text{Urinary Catheter Days}}{\text{Patient Days}}$ The Urinary Catheter Utilization Ratio is calculated by dividing the number of urinary catheter days by the number of patient days.	2015 Target: **HD = 0.40** Comparative Reference: NHSN 2013 = • ICU: 0-51 • Adult Ward: 0.43
14. Return to Acute Care within 30 Days of Admission (RTA-30 days)	$\dfrac{\text{Number of discharges in the month with Discharge disposition equals "Return to STAC" within 30 days of admission}}{\text{Total number of discharges for the month}}$ **X 100**	2015 Target: **HD = 8.31**
15. Finger Stick (FS) Blood Glucose	$\dfrac{\text{Total number of finger sticks resulting in Glucose measure between 80 and 180 mg/dl}}{\text{Total number of finger sticks}}$ **X 100** Percent of glucose measures between 80 and 180 mg/dl. This does not	2015 Target: **HD = 71.6%**

	constitute "tight control" or even "normal", but rather physiologic for a sick patient where low glucose is higher risk than high glucose. **Method:** Finger sticks collected electronically now. No exceptions. We accept that for a given patient, when glucoses are out of range, more repeat testing is ordered, at a frequency proportional to the number out of range, i.e., "keep checking until it is back in range."	
KEY QUALITY INDICATOR	**FORMULA / DEFINITION**	**Target / Threshold / Comp Ref**
16. Successful Intubations	$$\frac{\text{Number of "Successful" Intubations}}{\text{Total number of patients with intubation episodes}} \times 100$$ "Successful" is defined as within 3 attempts	**Baseline will be collected in 2016**
17. Multi-Drug Resistant Organisms (MDRO) LabID Reporting	Report the NHSN components MDRO and CDI Module for facility wide inpatient (FacWidIN) MDRO Laboratory Identification Events that are reported as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C-Diff). **MRSA:** All blood cultures positive for MRSA will be entered in the NHSN system regardless of when it was identified during the inpatient stay. Numerator: Patient Events reported in the NHSN Denominator: Patient Days Total Facility Wide and Total Number of Admissions **C-Diff:** All stool cultures positive for C-Diff will be entered in the NHSN system regardless of when it was identified during the inpatient stay. Numerator: Patient Events reported in the NHSN Denominator: Patient Days Total Facility Wide and Total Number of Admissions **NOTE:** Do Not enter more than one event in NHSN within a 14-day period.	**New for 2015. As of 12/2015 NHSN has not published data.**
KEY QUALITY INDICATOR	**FORMULA / DEFINITION**	**Target / Threshold / Comp Ref**
20. Healthcare Personnel Influenza	**NHSN Definition 08/2014** **(http://www.cdc.gov/nhsn/pdfs/hps-manual/vaccination/hps-flu-vaccine-protocol.pdf)** Influenza season is defined by NHSN as October 1st through March 31st or sooner if the vaccinations become available. Each hospital is required to enter a reporting for at least one month during the reporting period. Summary data required is total number of employees on payroll (full time, part-time and PRN employees are included) that worked at least	Incremental increase in compliance according to the Joint Commission and Healthy People 2020.

	one day during the defined influenza period. Inclusions: Also included are all physicians, licensed independent practitioners, advanced practice nurses, physician assistants, adult students/trainees and volunteers. Exclusions: All contract workers are excluded (JLL, Pharmerica, Rehab Care, etc). When answering the six (6) questions in the summary, questions 2-6 must equal question one (1). The formatted questions can be found in the link listed in this document. Annual Vaccination Survey is not required but highly recommended it be completed prior to entering you summary data.	
21. Clinical Index	Comprised of the 3 clinical measures: CLABSI, CAUTI and Restraint Rate. The individual rates are divided by their individual *base* rates to get the individual index. The individual indexes are **summed** to calculate the overall Clinical Index: Example: CLABSI = 1.64 divided by base rate of 2.33 = 0.70 Restraint = 65.00 divided by base rate of 70.00 = 0.93 CAUTI = 1.89 divided by base rate of 3.06 = 0.62 2.25 (sum) **Overall Clinical Index = 2.25** *NOTE: The base rates are standard across all facilities and do not change from year to year. Base rates were established in year 2010.*	2015 Target: **HD = 1.82**
22. Service Index	Comprised of 3 Patient Satisfaction HCAHPS discharge survey questions: #4 During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? #14 During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? #22 Would you recommend this hospital to your family and friends? The percentage of "top box" responses are **averaged** to calculate the overall Service Index: Example: Question #4 % Always = 85% Question #14 % Always = 90% Question #22 % Definitely Yes = 90% 88.33% (average) **Overall Service Index = 88.33%**	2015 Target: **HD = 75.20**

23. Patient Safety Index	Comprised of the 4 clinical measures: % Reposition Orders Executed, % Wound Dressing Completed, % Consistent Branden Scores and % Wound Education Completed The percentage scores are **averaged** to calculate the overall Patient Safety Index. Example: % Reposition Orders Executed = 82% % Wound Dressing Completed = 75% % Consistent Braden Scores = 93% % Wound Education Completed = <u>95%</u> 86.25% (average) **Overall Patient Safety Index = 86.25%**	2016 is the initial year for this Index. Q4 2015 data results will help inform target.
24. Reputation.com	Composite Score based on six components: Star Average, Volume, Recentness, Length, Spread, and Visibility. Reputation BSC Indicator Information.	2015 Target: **HD = 332**

Leadership Committee Indicators (not already listed in 1-24 above)

KEY QUALITY INDICATOR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Regulatory / Survey Activity	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Regulatory Plan of Correction Update	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Patient Satisfaction Survey Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Complaints / Grievances Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Contract Services Oversight	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Competency Evaluations	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Licensure Verifications	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Employee Satisfaction	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
KHAT Utilization	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Ethics Case Review Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Termination of Life Support	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Organ/Tissue Donation	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Occupational Incidents Analysis (Loss Prevention) & RCA trends	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Patient / Visitor Event Summary (related to EOC)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Safety Management	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Security Incidents Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Hazardous Materials/Waste Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Fire-Safety Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Medical Equipment Management Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Utility Systems Management Summary	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
CEO Physical Environment Compliance Oversight Checklist Review	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Environmental Tour Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Patient Safety and Reliability Committee Indicators (not already listed in 1-24 above)

KEY QUALITY INDICATOR	DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED	ADDITIONAL INFO
Code Blue Reviews / Outcomes	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Rapid Response Events / Outcomes	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Decannulation Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Consent to Treat Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Change of Condition Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Mortality Reviews	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Hospital Acquired Pressure Wound RCA Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Fall RCA Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Surgical Program / Invasive Procedures	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Critical Results-Read Back (General Tests & ABG Tests)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Critical Results-Timeliness of Reporting (General Lab and ABG)	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Cross-Match / Transfusion Ratio	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Transfusion Appropriateness	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Infusion Timeliness	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Blood Bank Testing Log	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Blood Product Transfusion Paperwork	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
RCA completed on all suspected blood transfusion reactions	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Radiology Dashboard	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Event Reporting System Trends Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Restraint Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
Sentinel Event/Near Misses/Sentinel Event Alerts Summary Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples
FMEA Report	See HELP document included in Leadership Committee Dashboard for details on content to be included in summary report.	See Dashboard HELP document for examples

Value Driven Transitions Committee Indicators		
KEY QUALITY INDICATOR	**DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED**	**ADDITIONAL INFO**
Hospital Performance Opportunity Trend Report. 3 Indicators: a) ALOS;	1) All Payer types to be reviewed; 2) HD Common Goal for Combined Medicare & Medicare Mgd ALOS of >=25 but may be additional specificity based on patient historical data of population types (ex: high volume complex, vent	See Dashboard HELP document for examples

b) Stay type percentages; c) CMI	patients may result in anticipated avg LOS well over 25) 3) Hospital-Specific Goals and/or analysis of trends for all other indicators.	
Care Management Barriers/Avoidable Delay Occurrences: 4 categories of "avoidable delay occurrences" collected and trended: a) physician-related; b) external causes; c) internal causes; d) patient/family-related. Also discuss trends with "barriers" identified through preadmission (barrier to admission) and/or daily flash meetings	1) All Payer types to be reviewed; 2) No HD or hospital-specific goals - but universal goal is to decrease trends/causes in all categories. 3) CMs to adhere to H-ML 10-020 policy when collecting, reporting and analyzing the data.	See Dashboard HELP document for examples
Clinical Coordination and Documentation Improvement: 6 categories: a) Top 10 DRGs b) Focus DRG Analysis c) Tier Rates; d) IDT Assessment Results (two metrics: "Role-Specific" and "IDT Overall Functioning" scores; e) Physician Snap Shot Report; f) Documentation Opportunity Trends	1) All Payer types to be reviewed with additional report for Medicare Top DRGs and Tier Rates; 2) Common hospital goals: a. Reduce/eliminate presence of filter DRG in top 10; percent tier rate of ALL DRGs is hospital-specific with goal of continued increased trend; b. Top 10 DRGs at highest tier; c. IDT	See Dashboard HELP document for examples
KEY QUALITY INDICATOR	**DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED**	**ADDITIONAL INFO**
Transition Disposition Rates and Analysis 8 categories: a) expiration; b) STAC (RTA); c) Acute Rehab; d) SNF/NH; e) Hospice; f) Home w/HH; g) Home w/o HH; h) Other	1) All payers; 2) Individual hospital goals for RTA rate	See Dashboard HELP document for examples

Denial Management Tracking: 2 categories: a) Reasons for denials; b) Trends in reviewer/payer types	Indicator Parameters: Informational only. Calculate denials by total denials received during the month in Payer category. Report PI plans on any medical necessity/auth/LOC denials and reasons.	See Dashboard HELP document for examples
Medical Necessity Reviews: 2 categories: a) Physician Advisor Referral Review; b) High Cost Outlier Oversight	1) All payers for PA referrals; 2) Medicare & Medicare Mgd patients for HCO review	See Dashboard HELP document for examples
Case Management Quality Monitoring: 3 categories: a) Case Management Documentation Audit (Admission, Continued Stay, Discharge); b) Resource Utilization Trends/ Opportunities; c) Departmental PI Activities	Case Mgmt Proficiency parameters: Ensure "proficiency" rates (90% or higher), "acceptable" rates (80%-89%) and "unacceptable rates" (<80%) are discussed and action plans proposed as per policy; 2)Resource Utilization Trends/Opportunities - parameters to be hospital-specific; 3)Departmental PI Activities - focuses on process improvement initiatives specific to CM and/or CCDI functions within a hospital based on trends.	See Dashboard HELP document for examples
TJC/CMS/State Regulatory updates/changes related to Utilization Management	Indicator Parameters: Awareness for updates that require compliance/monitoring	See Dashboard HELP document for examples
KEY QUALITY INDICATOR	**DESCRIPTION OF INFORMATION TO BE REVIEWED/ANALYZED**	**ADDITIONAL INFO**
Consultation Summary Report • Timeliness of Consultations • Timeliness of Consultation Reports	Summary Report of Consultation Reviews.	See Dashboard HELP document for examples
Medical Record Delinquencies Report Summary (Overall Delinquent Numbers / Percentage and Late H&Ps)	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. Data reported from monthly HIM statistics worksheet. H-IM 04-010A	See Dashboard HELP document for examples

Operative / Invasive Reports	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. H-IM 02-010	See Dashboard HELP document for examples
Order Entry and Usage - Verbal & Telephone Orders	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. See policies H-IM 02-020 (Concurrent Analysis of Orders) & H-IM 02-021 (Differentiation between Verbal and Written Orders). H-IM 02-021 PRO	See Dashboard HELP document for examples
Order Entry and Usage - Verbal & Telephone Orders	Summary Report. HIM Rep provides the data in an aggregated format with analysis of trends. See policies H-IM 02-020 (Concurrent Analysis of Orders) & H-IM 02-021 (Differentiation between Verbal and Written Orders). H-IM 02-021 PRO	See Dashboard HELP document for examples

Appendix C: Performance Improvement Tools

Item		Location
Annual Plans	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\ Annual Plan and Review ToolBox
Audit Tools	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Audit Tools
CCO Checklist	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\CEO-CCO Checklists\CCO Checklist
CEO Checklist	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\ Quality Management\ CEO-CCO Checklists\CEO Checklist
Dashboard training	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Committee Standardization\2016 Dashboard Training Sessions

webinars		
HVA Form	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Physical Environment\Emergency Management\Standardized Emergency Management Tools
ISMP Newsletters	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Pharmacy – Medication Mgmt\Medication Safety
PIT Documentation Template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation
PIT Commission / Charter Template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation
PIT Prioritization Grid	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\Quality Council\PIT Documentation
PIT Progress Report Template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Strategic Quality Plan\PIT Documentation
QC Evaluation Form	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\AnnualPlanandReviewTool Box\Strategic Quality Plan
RCA Form	Policy	Policy H-PC 05-002C
IDT Evaluation Form	CRL Path	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\IDT\Master IDT Assessment Tool
IDT Quality Crosswalk	CRL	Knect\Hospital Division\ClinicalResourceLibrary\Quality Management\IDT Crosswalk
Tracers	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\Tracers
Trend line chart template	CRL Path	Knect\HospitalDivision\ClinicalResourceLibrary\QualityManagement\Committee Standardization \Departmental PI Forms

APPENDIX D: Data Reporting Procedures

Data Reporting Procedures	Procedures
Reporting for Benchmark Report (BW) • Submission:	Benchmark data must be entered into the Data Entry Application in the Business Warehouse by the 8th of the month. After the 8th you will no longer have access to key your data. Contact Roxann Walker or Chastity Dailey at the Support Center if you are unable to key your data in order to receive further instructions.

• Corrections/Revisions	****TIPS WHEN SUBMITTING YOUR BENCHMARK DATA**** 1. Once you have keyed your data, ALWAYS double check your numbers. 2. If you are a NON-ProTouch facility entering Wound Initial/Difference scores, make sure your numbers match your Wound Care Initiative Sheet. Requests to correct previously reported data must be submitted via e-mail addressed to either Chastity Dailey or Roxann Walker.
Patient Satisfaction Surveys	Our 3rd party vendor, Deyta Inc., must receive your surveys by the end of business on the 5th of every month in order to be credited to the previous month. For example: Feb surveys must be received at Deyta Inc.'s procesisng center by March 5th to be credited to February. All surveys received between Feb 6 and Mar 5 will be attributed to Feb. All surveys received between March 6 and April 5 will be attributed to March, etc. If the 5th falls on a weekend or holiday, surveys must be received at Deyta on the last open business day prior to the 5th. It is strongly recommended that you send completed surveys to Deyta Inc. on a weekly basis. If you send your surveys once monthly and miss the deadline, you will have 0 surveys posted for that month. Reports are available via the KNECT/Hospital Division/Dey Systems Reports link by the 12th of each month.
NHSN Reporting	Events are entered monthly. NHSN submits quarterly (120 days after the end of the quarter) to CMS. Each hospital is required to enter their monthly reporting plans, summary data related to CLABSI, CAUTI, VAE, MRSA Blood Lab ID and Clostridium difficile (C-Diff) LabID data and patient specific events in the NHSN website by the 8th of the following month. Following the submission of data the hospital should run the CMS reports in the NHSN website to validate that data has been reported. Healthcare Personnel (HCP) Influenza data is also entered each year by the May 15th reporting deadline in NHSN. HCP includes all staff including students, volunteers, physicians and allied health professionals that were employed or credentialed in the facility for 1 day during the October 1st to March 31st influenza reporting period. *This requirement does not include contract workers at this time.* Influenza reporting also requires that a survey be completed by each hospital annually when the annual summary is completed. Each year the facility is to complete the NHSN Annual Survey with hospital specific information in the NHSN website by the end of February the following year.

CMS CARE Data Submissions (Quality Reporting Program)	Admissions Assessments: CMS requires an **admission** CARE Data Set record to be submitted no later than the 15th calendar day of the patient's admission for all patients admitted to a Long Term Care Hospital (LTCH) regardless of payer type.
	Discharge Assessments: CMS requires a **discharge** CARE Data Set record to be submitted for all patients discharged from the LTCH no later than 13 days (discharge date counts as day 1) post discharge regardless of payer type. This includes discharge assessments for all discharge types: Planned, Unplanned and Expired.
	Interrupted Stays: For purposes of the QRP, an Interrupted Stay is when a patient is transferred to a short-term acute hospital and returns to the LTCH within 3 calendar days (discharge day is day 1). Patients that return after Day 4 must have a Discharge Assessment completed for the discharge to STAC and a new Admission CARE Assessment completed for the "new admission."
	Following submission of Admission and Discharge CARE Data Set Records, a CASPER Validation report must be retrieved from the CMS site and reviewed to ensure all records were Accepted. Accepted records are documented as such in the LTRAX database. Records not accepted must be corrected and resubmitted to CMS. The CASPER Validation report must be stored in the secure CMS CARE Data Set Documents folder located on the Kindred Network.
	Information on mapping to the secure CMS Care Data Set Documents folder can be found in the Clinical Resource Library (CRL/CMS/CMS Mandatory Quality Reporting/CARE Assessment Process).

APPENDIX E: Crosswalk of Quality Council Meetings (Medical Staff Bylaws to 2016 Strategic Quality Plan)

Bylaws Section	Medical Staff Committee	Meeting Frequency	Number of MS Members	2016 SQP Committee	Meeting Frequency	Comments/Action to be Taken
9.4	Medical Executive Committee	Not specified but traditionally 10x per year.	Varies but typically 3-5 (Med.	No change	At least quarterly	None needed unless local bylaws were amended to

	(MEC)	Rules & Regs silent.	Dir., POMS, secy-Treasurer and any Med Dirs for specific services (ID, etc)			establish greater frequency
9.5	Credentialing Committee (if separate from MEC)	Not specified; typically monthly. Ad hoc meetings to approve appointments, reappointments are common	At least 3 (function may be performed by MEC)	No change	Not specified	No change
9.6	Quality Council	**9.6.2-h reports at least quarterly to MEC** on overall quality, appropriateness and efficiency of medical care provided in the hospital, and on quality and resource management monitoring, review and evaluation and improvement activities; and 9.6.2-i report to the GB on a regular basis regarding the results of ongoing performance assessment and improvement activities. **9.6.3 QC meets at least 10x/year**	At least 1 (President of the Medical Staff)	No change	At least quarterly, but may meet more frequently as determined by the QC leadership	Delete 9.6.3
9.7	Ethics	Ethics policy	2	Reports	At least	No change

		says "quarterly or as outlined in Med Staff rules/regs."		through Leadership	quarterly, more frequently as needed	
9.8	Operative and Other Invasive Procedures	9.8.2-e at least quarterly to QC	1-2	Reports through Patient Safety & Reliability	At least quarterly	No change
9.9	Blood Usage	9.9.2-d at least quarterly to QC	1-2	Reports through Patient Safety and Reliability	At least quarterly	No change
9.10	Medical Records	9.2.10-e at least quarterly to QC	1-2	Reports through Value-Driven Transitions	At least quarterly	No change
9.11	Medication Use, Nutrition, and Therapeutics	9.11.2-g at least quarterly to QC	At least 2	Reports through Patient Safety & Reliability	At least quarterly	No change
9.12	Infection Prevention	9.12.2-e at least quarterly to QC	At least 2	Reports through Patient Safety & Reliability	At least quarterly	No change
9.13	Utilization Review	9.13.2-d at least quarterly to QC	At least 2	Reports through Value-Driven Transitions	At least quarterly	No change
9.14	Clinical Laboratory	9.14.2-f at least quarterly	At least 1	Reports through Patient Safety & Reliability	At least quarterly	No change

KINDRED HOSPITAL – YEAR
PATIENT SAFETY & RISK MANAGEMENT PLAN

Data Elements for Consideration	Hospital Specific Performance	Hospital Specific Goal	Area of Focus (X)
# Claims within last 12 months	Flamingo 2015 – 2 Sahara 2015 – 1 DeLima 2015 – 0 Market 2015 – 3	Las Vegas Market 2016 – 0	
Employee Turnover Rate YTD	Flamingo 2015 – 19.1 Sahara 2015 – 24.0 DeLima 2015 – 24.1	Flamingo 2016 – 18.0 Sahara 2016 – 18.5 DeLima 2016 – 18.8	
HAPU Rate YTD	Flamingo 2015 – 0.47 Sahara 2015 – 0.75 DeLima 2015 – 0.57 Market 2015 – 0.60	Las Vegas Market 2016 – 0.77	x
CLABSI Rate YTD	Flamingo 2015 – 0.73 Sahara 2015 – 1.82 DeLima 2015 – 1.09 Market 2015 – 1.22	Las Vegas Market 2016 – 1.61	x
CAUTI Rate YTD	Flamingo 2015 – 2.07 Sahara 2015 – 2.83 DeLima 2015 – 1.97 Market 2015 – 2.35	Las Vegas Market 2016 – 1.87	x
Workers Comp Claim/FTE	Flamingo 2015 – 6.5 Sahara 2015 – 9.0 DeLima 2015 – 7.5	Las Vegas Market 2016 – 4.0	
Employee Engagement Index Score	Flamingo 2015 – 4.07 Sahara 2015 – 3.93 DeLima 2015 – 3.93 Market 2015 – 4.08	Flamingo 2016 – 4.14 Sahara 2016 – 4.0 DeLima 2016 – 4.0 Market 2016 – 4.2	

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		Las Vegas Market 2016	
RTA Rate YTD	Flamingo 2015 – 14.1 Sahara 2015 – 14.7 DeLima 2015 – 8.63 Market 2015 – 13.18	Las Vegas Market 2016– 13.3	x
Customer Service Index	Flamingo 2015 – 92.35 Sahara 2015 – 88.37 DeLima 2015 – 84.57 Market 2015 – 89.49	Las Vegas Market 2016– 75.2	
Falls Rate YTD	Flamingo 2015 – 2.30 Sahara 2015 – 3.97 DeLima 2015 – 2.99 Market 2015 – 3.15	Las Vegas Market 2016– 3.99	x
Decannulations YTD	Flamingo 2015 – 1.66 Sahara 2015 – 1.29 DeLima 2015 – 0.93 Market 2015 – 1.39	Las Vegas Market 2016– 2.5	
Med Errors with Harm	Flamingo 2015 – 0 Sahara 2015 – 0 DeLima 2015 –3	Las Vegas Market 2016– 0	

Evaluate performance of above indicators, identify those that require focused attention on the right column; complete the action plan on the next page. Track action plan and progress throughout the year.

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Names in this page have been removed base on NRS4369.843.

KINDRED HOSPITAL – YEAR
PATIENT SAFETY & RISK MANAGEMENT PLAN

Area of Focus	Plan	Responsible Party	Planned Completion Date
HAPU Rate YTD	1) Initiate PIT Team – Done at each facility ➤ Sahara February 2015 ➤ Flamingo May 2015 ➤ DeLima October 2015 2) Perform Mini RCA on all HAPU 3) Have Wound Consultant Evaluate all HAPU for Staging Criteria 4) Monitor all HAPU through Wound Tracking Tool 5) Send Wound Tracking Tool to West Region Monthly 6) Employ frontline staff in each Mini RCA 7) Employ frontline staff in PIT Team	Reported through Patient Safety and Reliability	September 1, 2016
CLABSI Rate YTD	1) Reconvene Task Force for Market 2) Conduct review of each CLABSI 3) Involve frontline Staff in review 4) Central Line Dressing Monitoring weekly for proper care and barrier assurance 5) BioPatch to conduct Point Prevalence Study 6) Continue monitoring of PICC Line Placement and adherence to technique 7) Use of Stat Caps with CHG start 1/2016	Reported through Patient Safety and Reliability	June 30, 2016
RTA Rate YTD	1) Continue Market PIT Team 2) Monitor RTA and Change in Internal Status 3) Perform Mini RCA on each RTA and Conduct Post Huddle for Improvements 4) Conduct Peer Review on unusual RTA data 5) Word on Physician Involvement in Recruiting necessary specialties to consult versus send out patients	Reported through Patient Safety and Reliability and Leadership	Ongoing - December 1, 2016
Falls Rate	1) Continue market Falls PIT 2) Monitor falls for rate and conduct Post Falls Assessments on all fall events 3) Improve Call Bell Response times 4) Conduct Hourly Rounding monitoring	Reported through Patient Safety and Reliability	July 1, 2016

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KINDRED HOSPITAL – YEAR
PATIENT SAFETY & RISK MANAGEMENT PLAN

	5) Set up No Pass Zones and keep staff accountable 6) Conduct education on scoring the Falls Score in Protouch. Individually educate changes in score that do not match patient assessment.	Ongoing - December 31, 2016
Customer Service	1. Addition of Patient Relations Representatives 2. Re-vitalize Leadership Rounding (ongoing) 3. Customization of Patient/Family Handbook for each campus and Welcome Packet 4. Implementation of Hourly rounding by staff (ongoing) 5. Servant Leadership and Culture of Service Program Training 6. Implemented new Meal Metrics to improve satisfaction with food Flamingo and Sahara with DeLima not participating due to contract) 7. Development of Patient/Family Advisory Council (Implement by 4th quarter 2016) 8. Participation in NHA Patient and Family Advisory Council Workgroup (every other month) 9. Revise Patient Safety handbook , complete by end of 3rd quarter 2016	Reported through Leadership Committee

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PATIENT SAFETY PLAN

LAKE'S CROSSING CENTER

DEPARTMENTAL PLAN FOR FISCAL YEAR 7/01/2015-6/30/2016

GOAL 1: Improve the accuracy of patient identification.

We have started to include a third picture identification with the medication administration to reduce to zero the number of misidentification errors.

We have taken steps to reduce distraction during all phases of the medication administration process.

We have instituted a name alert process for those who share a last name.

Performance improvement monitoring: we have two misidentified patient error and are close to meeting this goal.

Follow- up: We have not met this goal. Discussed in performance improvement t and assessing for trends individual coaching on nurses who have problems with this procedure. We are considering a further identification system a wrist band and printed stickers to eliminate hand writing errors.

GOAL 2: Improve the effectiveness of communications among caregivers.

All discharges will be reviewed by a supervisor to insure that follow up caregivers are given all pertinent information. Strict departmental inter shift reporting will be completed to identify all potential safety concerns including PRN medication, potential for aggression, self-harm, seizure precautions, health care acquired infections and fall risks.

Performance improvement monitoring: Peer review, supervisor involvement, and monitoring the electronic medical record. All falls will be investigated to reduce future risk factors; no more than one fall a quarter. Nosocomial infections have been eliminated this period but we are alert for MRSA from the jail. A fall policy has been implemented, and a patient identified with high risk that is being monitored by one to one MHT from AZ agency. Dr. Scott has integrated into the providers and History and physical are timely and communicated well.
Follow-up: we have met this goal.

GOAL 3: Improve the safety of using medications.

Anytime a physician stops a medication secondary to an untoward reaction, a document will be sent to the pharmacy to prevent future orders for that medication. Pharmacy and nursing leadership will meet monthly to identify safety issues, and report to the Patient Safety Committee.

Performance improvement monitoring: Medication errors to be tabulated and broken down for analysis. Supervisors to offer guidance in major medication reactions, for example NMS and signs of specific toxicity, as well as how to communicate with physicians effectively. Nursing leadership will evaluate this communication with the Medical Director.

Follow-up: Communication training in place, and all nurses to receive the same qualified nurse training to assist with the face to face assessment of the combative client. We have transitioned well to loss of afterhours pharmacy oversight and no override has been noted with client safety issues. We hope to use AVATAR to coordinate better with the M.D. regarding adverse drug reactions when discontinuing medication.

GOAL 4: Reduce the risk of healthcare associated infections.

All infections are monitored by the Infection Control Committee. Patterns of Nosocomial infections will be identified and remedied. Emphasis on MRSA treatment and prevention will be maintained.

Performance improvement monitoring: MRSA infections will be identified on admission, cultures performed, and isolation with prevention methods used. No more than one Nosocomal MERSA infection a quarter. Compliance with AB280, and reporting mandated data to the Health Safety Network however we have sought support from the division.

Follow-up: AB 280 compliance is problematic with only a part time performance improvement staff member. A facility Infection prevention committee is now organized and extremely active. We have made great strides in documenting infection control are participating in the division's attempt to offer TDAPT and hepatitis A&B vaccine to every staff, patient and staff family members and also increase the amount of influenza vaccine given.

GOAL 5: Accurately and completely reconcile medications across the continuum of care.

All admission medications will be written on the day of admission, reviewed by the medical doctor and reviewed by the pharmacy for accuracy, efficacy and safety.

Performance improvement monitoring: Monitoring of the nursing care plan, first dose of medication documentation, and insuring treatment planning for pain and infection. No more than one exception per quarter.

Follow-Up: We have met and continue to support this goal.

GOAL 6: Reduce the risk of patient harm resulting from falls.

Identify on Admission and throughout the stay, any fall risk and monitor closely.

Performance improvement monitoring: All falls will be investigated to reduce future risk factors; no more than one fall a quarter. Monitor care planning through peer review; no more then one exception a quarter.

Follow-up: One falls this period. Greater diligence in seizure disorder identification is noted as is greater awareness of our ageing and cognitively impaired patient's safety needs in maximum security environment.
We have instituted a one on one with our greatest fall risk.

GOAL 7: Encourage patients' active involvement in their own care as a patient safety strategy.

All primary care nurses to meet weekly with their clients to incorporate self-identified hazards during care.

Follow up: While anecdotal evidence suggests greater involvement, I am challenged to implement evidence based performance improvement indicators.

Performance improvement monitoring: Peer review of nursing care documentation to identify training needs and building of a therapeutic relationship. No more than one exception a quarter.

Follow up: Patient education has been identified as a challenge thru out the therapeutic relationship in the department. Training will be initiated to include patient education in the nursing care plan. Very little progress in this area, therefore I will bring the issue to Leadership and the Clinical body for input and measurable goals.

GOAL 8: The organization identifies safety risk inherent in its patient population.

The organization is currently reviewing the restraint and seclusion process and documentation to ensure the least restrictive environment possible.

Performance improvement monitoring: Adaption of the draft policy and implementation by the next report.

Follow-up: The need for face to face assessment and increased communicating with the attending physician, at the time of seclusion and restraint has been met and we continue to work with the Agency leadership to reduce seclusion hours per patient stay days.

The Nursing Department's Mission is to provide a superior level of care in a maximum security setting. All of the nursing staff strives to perform care at a consistent level of excellence in a challenging environment.

Effective Date:	*05/2015*
Reviewed Date:	*02/2016*
Revision Date:	*02/2016*
Next Review:	*02/2017*
Owner:	*Name has been removed base on NRS439.843.*
	Clinical Officer
Policy Area:	*A. Patient Rights and Organizational Ethics*
References:	
Applicability:	*Acadiana Management Group*
	North Alabama Specialty Hospital
	Lafayette Physical Rehabilitation Hospital

Patient Safety Plan, A.1.26 - LAS VEGAS ONLY

POLICY:

This is an internal safety plan designed to assist in the improvement of the health and safety of patients treated at AMG Specialty Hospital Las Vegas. The goal of the plan is to reduce and eliminate any potentially unsafe practices thereby promoting an environment of safety for our patients.

To notify patients; who are involved when a sentinel event occurs or of any infections present on admission and/or if they have acquired infections at AMG Specialty Hospital Las Vegas; pursuant to Nevada statutes. The plan is submitted to and approved by the governing board of AMG Specialty Hospital Las Vegas as required in NRS 439.865.

AMG Specialty Hospital Las Vegas's health care providers were notified of the initial plan and are able to freely access the plan for any completed updates to facilitate compliance with NRS 439.800-890. (Notification 10/09, 7/11, 2/11, 2-12, 2-13, 10-13, 2-14)

AMG Specialty Hospital Las Vegas (AMG) will maintain a Patient Safety Plan that complies with the statutes and rules pursuant with NRS 439.800-890 and NAC 439.900 to .920 inclusive of 2010 Regulations.

Established a Patient Safety Committee, pursuant to NRS439.875, that:

- Meets monthly
- Is Chaired by the Patient Safety Officer
- Includes the Infection Control Officer
- Contains at least three health care providers
- Includes one member from Pharmacy
- Includes one member from medical staff
- Includes one member from nursing
- Includes one member of the executive or governing body.

AMG Specialty Hospital Las Vegas has designated a Patient Safety Officer (PSO) who:

- Serves on the Patient Safety Committee, (PSC)

- Reports to the PSC Monthly, Quarterly and Yearly. Supervises the reporting of all sentinel events with active participation of the PSC. (NRS439.835)
- Takes action he/she determines necessary to ensure the safety of patients as a result of any investigation involving a safety risk or sentinel event that has occurred at AMG Specialty Hospital Las Vegas.
- Reports any actions taken to the Patient Safety Committee, the state reporting agencies and communicates with the patient as per NRS439.855 (2).0.

AMG Specialty Hospital Las Vegas has designated the CCO who functions in the role of Infection Control Preventionist and as the Infection Control Officer (ICO) +who:

- Serves on the PSC
- Monitors the occurrences of infections to determine the number and severity of infections.
- Reports to the PSC concerning the number and severity all infections at AMG.
- Takes such action as he/she determines is necessary to prevent and control infections alleged to have occurred at AMG.
- The Infection Control Officer or staff she designates notifies patients who have been admitted with POA, Present on Admission Infection(s), or who develop an infection at the facility (HAI), will be notified within 5 days of the Infection Control Officer's positive identification of the infection(s) as required by the statute.
- Reports Monthly, Quarterly and Yearly to the PSC.
- Shall carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.
- AMG Specialty Hospital Las Vegas has less than 175 beds and therefore, will comply with 439 SEC 3. 4; AMG Specialty Hospital Las Vegas complies with this regulation and will:
- Maintain the records of completion of the required training in the employee file.
- Maintain periodic reviews by a certified infection preventionist consultant
- AMG designates a qualified backup person, who has received the required training, to carry out the duties of the Infection Control Officer, when he/she is absent per statute.

Patient Safety Committee:

- Will receive reports from the Patient Safety Officer and Infection Control Officer pursuant to NRS 439.870
- Will review and evaluate compliance with notification of patients who have been admitted with Present on Admission infection (POA) or developed an infection at the facility HAI, as required by the statute.
- Will post in publicly accessible areas and provide, to patients, information on reporting facility-acquired infections, including the contact information to the Health Division.
- The information provided to each patient includes all statutory requirements pursuant to 439.870 paragraph (a) of subsection.
- Has established pursuant to NRS 439.875 patient safety checklists and patient safety policies for use by: (The patient safety checklists adopted, pursuant to NRS 439.875 AB 280 subsection 1, follow protocols to improve the health outcomes of patients at AMG Specialty Hospital Las Vegas).

    a. Providers of health care who provide treatment and/or care;

    b. Other personnel who provide treatment or assistance to patients;

    c. Employees of the medical facility who do not provide treatment but whose duties affect the health or welfare of the patients including janitors.

    d. Persons with whom the medical facility enters into a contract to provide treatment or services which may affect the health or welfare of patients at the facility.

- Has a policy for appropriately identifying patients before providing care. Located in Section K care of patients in the AMG Policy and Procedure Manual.

- Shall monitor and document the effectiveness of the patient identification policy and the use of patient safety checklists adopted pursuant to NRS 439.875.

    a. Will submit a report to the Director of the Legislative Counsel Bureau on or before July 1 of each year, pursuant to NRS 439.875.

- Shall evaluate the reports of sentinel events alleged to have occurred, submitted by Patient Safety Officer.
- Review and evaluate the quality measures carried out to improve the safety of patients who receive treatment at AMG Specialty Hospital Las Vegas.
- Make recommendations to the executive or governing body regarding any sentinel events for the previous calendar quarter and the plans to reduce the number and severity of events at AMG Specialty Hospital Las Vegas.
- All records are considered confidential and protected from discovery, as described in NRS 439.265 and in NAC 439 regulation R044-10 Sec. 6, 5. and NRS 239.0115.

PATIENT SAFETY GOALS:

Selected recommendations will be monitored on a routine basis to evaluate AMG Specialty Hospital Las Vegas's effectiveness in implementation and compliance with National Patient Safety Goals.

Goals are as follow:

- Improve the accuracy of patient identification
- Increase the effectiveness of communication among caregivers
- Improve the safety of giving medications
- Reduce the risks of health care infections
- Improve the response to alarms in the care environment.
- Improve the care of patients who require indwelling catheters and tubes.
- Use bundles to improve care patterns
- Accurately and completely reconcile medications across the care continuum
- Reduce the risk of patient harm resulting from falls
- Encourage patients active involvement in their care as a patient safety strategy
- AMG Specialty Hospital Las Vegas will identify risks inherent to its patient population
- Improve recognition and response to changes in condition

DISCLOSURE OF UNANTICIPATED OUTCOMES:

AMG Specialty Hospital Las Vegas will follow the policy "Effective Patient Communication" in relating to the patient and when appropriate the patient's family about outcomes of care that the patient (or family) must be knowledgeable about in order to participate in current and future decisions affecting the patient's care and unanticipated outcomes of care.

Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job related aspects of patient safety including the methodology to report medical/healthcare errors and on the provision of an interdisciplinary approach to patient care for the optimal delivery of health care.

Unanticipated outcomes, including sentinel events, will be reported internally and externally as per AMG Specialty Hospital Las Vegas's policies. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and regulations. NAC 439.900-.920 and NRS 439.800 to .890, 2013

The Patient Safety Committee will report to AMG Specialty Hospital Las Vegas's Committee of The Whole (COW) meeting regarding any Performance Improvement (PI) or plans implemented subsequent to patient safety issues or sentinel events.

Upon identification of an unexpected occurrence the patient care provider will immediately:

- Perform the necessary healthcare interventions to protect and support the patient's clinical condition.
- Perform necessary healthcare interventions to reduce the potential risk to other patients.
- Contact the patient's physician to report the unexpected occurrence.
- Report the unexpected occurrence to their immediate supervisor and complete an event report.
- The Supervisor will immediately call their director and report the occurrence.
- Submit the event report to the CCO or designee.
- Forwards to Risk Management.
- If a PI team is initiated to assess the unexpected occurrence the care provider will make them self available to the team.

PATIENT SAFETY PLAN:

The scope of the Patient Safety Plan encompasses the patient population, visitors and staff (including medical staff).

The Plan addresses the maintenance and improvement in patient safety in every department throughout AMG. Areas the plan covers are:

- No harm errors: those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome but do not result in a physical or psychological negative outcome, or the potential for a negative outcome for the patient.
- Medication errors
- Infection Control Program:

    1. The Infection Control Program is contained in the AMG Policy and Procedure Manual Sec. R Surveillance, Prevention and Control of Infection and follows the Centers for Disease Control, CDC, National Health Safety Network, NHSN, (nationally recognized infection control guidelines).

    2. Was developed under the direction of a certified infection preventionist (CIP), and as a less than 175 bed facility does not require a CIP, but the ICO has passed an infection preventionist course and keeps yearly training up to date with at least 4 CEU's of infection prevention related continuing education. NAC 279, SB 339

    3. Includes a "backup" person as required per statute and addressed under the CCO section of this document; keeps yearly training up to date with at least 4 CEU's of infection prevention related continuing education.

- Adverse drug reactions
- Restraints
- Falls
- Hazardous conditions; any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Sentinel events "Sentinel Event means an event included in Appendix A of "Serious Reportable Events in Healthcare-2011 Update: A Consensus Report", published by the National Quality Forum or, if revised, the most current version of the list of serious reportable events, published by the National Quality Forum.

If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist. (NRS 439.830)

- ◦ The Sentinel Events Policy can be found in the Leadership Manual
- ◦ For reporting sentinel events refer to the Sentinel Events Policy.

The Patient Safety Plan will place an emphasis on important AMG Specialty Hospital Las Vegas and patient care functions:

- Patient rights
- Assessment of patients
- Care of patients
- Patient/Family education
- Continuum of care
- Infection Control – Surveillance, control and prevention of infection
- Leadership
- Organization Performance Improvement
- Information management
- Human Resources management
- National Patient Safety Goals
- Life Safety
- Record of Care, Treatment and Services.

METHODOLOGY:

The Patient Safety Committee:

- Is responsible for the oversight of the Patient Safety Plan.
- Meets monthly and receives a report in regards to the patient safety issues that occurred during the past calendar month.
- Includes by statute the Patient Safety Officer, the Infection Control Officer, at least three healthcare members; one member of the medical staff, pharmaceutical and nursing staff and a member of the executive or governing body attend each meeting.
- Is a sub-committee of the General Safety Committee
- Will review internal and external data, PI activities, sentinel events, infection control.
- Will direct updates of the policies and procedures necessary secondary to sentinel event occurrence, and review those policies at the first meeting post update.
- Will facilitate training as needed post sentinel event.
- Will review the status of the reporting progress to the Health Division, the root cause analysis team appointments and the performance of the Patient Safety Officer in completing the necessary tasks.
- Will review and evaluate the quality measures carried out to improve the safety of patients receiving treatment at AMG.
- Will review and evaluate the quality measures carried out to prevent and control infections at AMG.
- Will review and evaluate the number of patients notified of any infections acquired at AMG per statute.
- Members of the sub-committee may or may not attend the full safety meeting.

The Patient Safety Officer and Infection Control Officer:

- Will be responsible for the administration of the plan.
- Will submit a monthly report to the PSC

- Will prepare, quarterly, a report for the PSC that covers any patient safety related issues that have occurred in the preceding 3 months.
- Will submit an annual report to the committee covering the past year.

NEW PROCESS DESIGN:

When the Patient Safety Committee

- Designs a new process, function, or service, it will utilize a standard document format for planning, implementing and evaluating the design and will consult with the administration team to facilitate the process and ensure all aspects and expectations are clear.
- Will take in to account the Mission Statement and Values of AMG Specialty Hospital Las Vegas, the needs of patients, staff and others when determining whether the program is clinically sound and current.
- The process foundation will be evidence based.
- Will consult a variety of information sources and incorporate available information from within the organization and other organizations about potential risks to patient safety, including the occurrence of sentinel events, in order to minimize risks to patients affected by the new/redesigned process, function or service.
- Will recommend the scale of the pilot program and monitor progress to determine whether the proposed design/redesign is an improvement.

REPORTING SAFETY AND QUALITY CONCERNS:

- An effective Patient Safety Plan cannot exist without optimal reporting of unexpected occurrences.
- All reporting will be received in a non-punitive manner in its management of errors and occurrences.
- All staff should feel free to report unexpected occurrences without fear of reprisals.
- Errors occur due to a breakdown of systems and processes and require event reports and full notification of the medical and administrative staff.
- AMG Specialty Hospital Las Vegas will use reporting to place the focus on improving systems and processes. The focus will be placed on remedial actions to assist rather than punish staff members. Any employee who has concerns about the safety and/or quality of care provided at AMG Specialty Hospital Las Vegas is encouraged to report their concerns to:
  - Their Supervisor
  - CCO, Department Directors
  - The Patient Safety Officer
  - Safety Officer
  - Infection Control Officer
  - CEO

Any individual in any department who identifies a potential safety issue will immediately notify his/her supervisor.

- The supervisor or director of the department will prepare a report for the Patient Safety Officer and potentially initiate a PI review to assess relevance of initiating a PI team.
- No harm errors require completion of an event report, all normal notifications, and a review by the PSC
- Mild to moderate adverse outcomes require immediate clinical interventions, notification of the patient's physician, response to related physician orders, completion of an event report and all notifications. The

staff then documents the facts in the medical record and an event report is submitted to Action Cue and the Patient Safety Officer reviews for submittal to the PSC.

- Adverse Drug Reactions: require staff to perform any clinical interventions to support and protect the patient, notification of the physician responsible for the patient, implementation of any subsequent orders, notification of the Pharmacy and all other required notifications as per policy, documentation of the facts in the medical record and on an event report. (Medication errors that are No Harm, moderate adverse outcomes or adverse reactions must be reported to the CCO and Pharmacy). The director of Quality will review the event report and if a sentinel event is suspected the Patient Safety Officer will be notified for further communication with the Patient Safety Committee.
- Hazardous Condition/Patient Safety issue: as appropriate, and if possible, staff will contain any hazardous condition or patient safety issue. Staff identifying a hazardous condition or a potential patient safety issue will immediately fill out an event report and complete all notifications as per policy.
- Event reports that relate to patient safety will be reported by the supervisor to the Patient Safety Officer. PI will be done as appropriate. The PSC will review.
- Sentinel Event: staff will perform any necessary clinical assessments and interventions to support and protect the patient, notify the physician responsible for the patient, carrying out any orders subsequent to the event and then follow the Sentinel Events Policy and Procedure. The Patient Safety Officer will notify The Patient Safety Committee (PSC) who will review and respond to the potential sentinel event at the nearest meeting date possible. Any reporting to the SE registry is per statutes and AMG Specialty Hospital Las Vegas sentinel events policy.
- AMG Specialty Hospital Las Vegas Policies such as the Sentinel Event Policy will determine the organizational response to unexpected occurrences. All sentinel events will have a root cause analysis conducted as pursuant to NAC 439. The determination of the Patient Safety Committee members, based on internal and external data analysis and prioritizing of patient safety will determine if further remedial action necessary for identified occurrences, proactive occurrence reduction activities, or if a FEMA (Failure Mode Effects Analysis) will be performed. External notifications will be carried out as outlined per NAC 439.900 to .920, and NRS 439.800 to .890.

EXCEPTIONS TO NON PUNITIVE REPORTING:

- All responses to unexpected occurrences will be investigated and any disciplinary action will be subsequent to that investigation;
- In the event that staff competency is the root cause for a pattern of errors; AMG Specialty Hospital Las Vegas management will make every reasonable effort to ensure staff can reliably deliver safe care. If it becomes clear that a staff member cannot practice in a reliably safe manner, in spite of education and counseling, this situation will be treated as a staff competency issue through disciplinary procedures.
- When staff knowingly performs intentional acts with intent to harm or deceive a patient possible disciplinary action may ensue.

SENTINEL EVENTS:

The policy regarding sentinel events can be found in the leadership manual and includes but is not limited to the following:

- Reporting process, procedure for reporting and the time line for compliance.
- Professional or emotional support for staff involved in a sentinel event.
- Root Cause Analysis and/or action plan processes
- Staff Members role in the process resolution
- Availability of training or personal consultation for any staff involved.

- Feedback from patients, family and staff.
- Staff opinions, needs and perceptions of risks to patients, and requests/ suggestions for improving patient safety.
- Disclosure to the patient/patient family is outlined in the Effective Patient Communication Policy and the Sentinel Event Policy and Procedure and completed as per the statutory requirements (within 7 days). This disclosure is an important patient right.
- Staff will educate patients and families about their role in facilitating safe delivery of care.
- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job related aspects of patient safety including the need and method to report unexpected occurrences and the provision of an interdisciplinary approach to patient care to facilitate the optimal delivery of health care.
- Unexpected occurrences, including sentinel events, will be reported internally and externally, per AMG Specialty Hospital Las Vegas Policy, NAC 439.900 to .920, Reg. and NRS 439.800 to .890. External reporting will be in accordance with all state, federal and regulatory body rules, laws and requirements.
- Patient Safety Reports will be submitted by the Patient Safety Officer to the Patient Safety Committee for review and further for medical, executive and governing body review.
- A quarterly Patient Safety Report from the Patient Safety Officer/Infection Control Officer/Committee will be presented to the Committee of the Whole (COW) including unexpected occurrences, Sentinel events and the actions taken to improve patient safety, reduce patient risks, and in response to actual occurrences and re activity.
- The Patient Safety Committee will on a yearly basis evaluate the effectiveness of the Patient Safety Plan; review the Patient Safety Checklists, review policies related to patient safety and update as needed and changes will be present to the MEC for approval as with all Policies and Procedures.
- Quarterly the Patient Safety Committee will report, to the governing body, on the number of sentinel events; as well as the number and severity of infections that occurred at AMG during the preceding calendar quarter.
- On or before July 1 each year, the PSC will submit a report to the Legislative Counsel Bureau that includes information regarding the past years development, revision and usage of the patient safety checklists, patient safety policies and a summary of the annual review. (Pursuant to NRS 439.875.)

Attachments:

No Attachments

Name has been removed base on NRS439.843.

	Approver	Date
	Corporate Director of HIM:	02/2016
	Corporate Director of QAPI:	02/2016
	Corporate Chief Clinical Officer:	02/2016

Policy/Procedure Title	Patient Safety Plan	Manual Location	Administrative		
Policy/Procedure # ADM 038		Effective	7/2001, Revised 2/06, 9/10, 1/12, 4/14, 5/15	Page	1 of 8
Department Generating Policy	Risk Management and Quality and Clinical Transformation				
Affected Departments	Hospital Wide – Mesa View Regional Hospital				
Prepared By	Name has been removed base on NRS439.843.	Dept/Title	Risk Management		
Dept / Committee Approval (If Applicable)		Date/Title			
Dept / Committee Approval (If Applicable)		Date/Title			
Dept / Committee Approval (If Applicable)	06/09/15	Date/Title			
Medical Staff Approval (If Applicable)	06/16/15	Date/Title			
Board Approval (If Applicable)	06/23/15	Date/Title			

PURPOSE

The purpose of the Patient Safety Plan is to provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services. The goal of the Patient Safety Plan is to provide a safe environment for patients and their families. The approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at the Hospital. The purpose includes creating an environment that encourages:

- Recognition and acknowledgment of risks to patient safety and medical/health errors;
- The initiation of actions to reduce these risks;
- The internal reporting of what has been found and the actions taken;
- A focus on processes and systems;
- Minimization of individual blame or retribution for involvement in a medical/healthcare error;
- Organizational learning about medical/healthcare errors;
- Support of the sharing of that knowledge to effect behavioral changes in itself and other health care organizations; and

- Disclosure of the outcomes of care, treatment and services.

The Patient Safety Plan developed by the interdisciplinary Patient Safety Committee and approved by the Quality Improvement Council, the Medical Executive Committee, and the Board of Trustees, outlines the components of the organization-wide Patient Safety Program.

SCOPE OF ACTIVITIES

The Patient Safety program is an organization-wide program that includes and integrates all activities within the organization and CHS PSO, LLC. which contributes to the maintenance and improvement of patient safety, healthcare quality and healthcare outcomes.

The scope of the Patient Safety Program involves an ongoing assessment, using internal and external knowledge and experience, to prevent occurrence of errors and to maintain and improve patient safety. Patient safety event information from aggregated data reports and individual event reports will be reviewed by the Patient Safety Committee to prioritize organizational patient safety activity efforts.

In addition to internal knowledge and experience, the services and information that the CHS PSO, LLC. offers will be reviewed and evaluated to include:
- Best Practices and Took Kit Development;
- Comparative Analysis of Adverse Event Reported in the Event Reporting System;
- Unsafe Behavior Evaluations;
- Raise safety awareness through the internal publication of anonymized Action Plans from root cause analysis;
- Develop and publish Patient Safety Alerts; and
- Monthly Comprehensive Risk Assessments.

Patient Safety Event Work Product:

Types of patient safety events, adverse outcomes, or medical/health care errors included in data analysis are:

- Event Reports- those events and outcomes reportable to the Risk Manager by an Event Report (Form RM 3301) include processes and outcomes of care that may result in no harm through serious injury or death. Examples include falls, medication variances, adverse drug reactions, intravenous therapy variances, procedure variances, procedure complications, patient complaints and AMA and elopement discharges. These may also include near miss events. (Reference Event Reporting policy).
- Hemolytic transfusion reactions reported through the transfusion review channels.
- Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.
- Serious Safety Event & Sentinel Event: applies to events that have resulted in an unanticipated death or major permanent loss of function, not related to the natural

course of the patient's illness or underlying condition. In addition, there are other event types that are considered sentinel due to the severity of the event even though the outcome was not death or permanent loss of function unrelated to the natural course of the patient's illness or underlying condition, see Sentinel Event Policy.
- Serious Safety Event & Sentinel event criteria and the procedures involved are detailed in the sentinel event and root cause analysis policies and procedures including definitions of near misses, which require a root cause analysis.
- Never Events and Hospital Acquired Conditions including:

Surgical events:
> Surgery performed on the wrong body part;
> Surgery performed on the wrong patient;
> Wrong surgical procedure performed on a patient;
> Unintended retention of a foreign object in a patient after surgery or other procedure;
> Intraoperative or immediately postoperative death in an American Society of Anesthesiologists Class I patient; or
> Artificial insemination with the wrong sperm or donor egg

Product or device events:
> Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility;
> Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used for functions other than as intended; or
> Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility e.g., luer connecters are implicated in or contribute to many of these errors because they enable functionality of dissimilar tubes to be connected.

Patient protection events:
> Infant discharged to the wrong person;
> Patient death or serious disability associated with patient elopement (disappearance); or
> Patient suicide or attempted suicide resulting in serious disability, while being cared for in a health care facility

Care management events:
> Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration);
> Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products;
> Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility;
> Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility;
> Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates;

Stage 3 or 4 pressure ulcers acquired after admission to a health care facility; or
Patient death or serious disability due to spinal manipulative therapy

Environmental events:
Patient death or serious disability associated with an electric shock or electrical cardio-version while being cared for in a health care facility;
Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility;
Patient death or serious disability associated with a fall while being cared for in a health care facility; or
Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility.

Criminal events:
Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
Abduction of a patient of any age;
Sexual assault on a patient within or on the grounds of the health care facility;
Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the health care facility; or
Environment of care significant incidents involving employee, visitor, utility or property damage

Sources of external knowledge and experience include the Sentinel Event Alerts. Published by The Joint Commission, safety alerts published by the Food and Drug Administration, Patient Safety Alerts, adverse outcome and lessons learned from RCA's, information from insurance carriers and other private and public healthcare safety organizations.

The scope of the organization-wide Safety Program encompasses all people including the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility, as well as employee safety, physical plant and facilities, equipment and supply-related safety issues, among other safety issues. To promote efficiency, there is an Environment of Care Committee, chaired by the Environmental Safety Officer, that addresses employee events and safety, workers compensation, needle sticks and products, visitor Events, hazard surveillance, and the safety management plans. To promote integration, communication and analysis of inter-related issues, there is cross membership between the committees, and both committees report to the Quality Improvement Council for oversight and further integration of related issues. Physician peer review of medical errors is also conducted at the Quality Improvement Council level (or at their direction).

The Serious Safety Event Rate (SSER) calculation will then be reviewed on a monthly basis. The SSER should be considered Patient Safety Work Product and will be reported to the following council/committees, Patient Safety, Quality Improvement,

Medical Executive and the Board of Directors. This rate will also be reported to the Patient Safety Committee and the CHS PSO.

The Patient Safety Committee is composed of a physician chairperson who is also a member of, and liaison to, the Quality Improvement Council. Other members include the Chief Quality Officer/QMRC, administrative representation such as the assistant CEO or COO, nursing leadership representative(s), including hospital, long term care, a pharmacist, and appropriate other medical and organization staff.

The meeting frequency should be at least quarterly. The Patient Safety Committee will appoint a Patient Safety Officer. The organizations' Risk Manager will serve as the Patient Safety Officer in most instances.

Procedures

Committee responsibilities:

1. The interdisciplinary Patient Safety Committee is responsible for the oversight and management of the Patient Safety Program. This includes making recommendations to organization leaders regarding the adequacy of resources allocated to support patient safety activities. The committee will oversee data and analysis in order to prioritize patient safety activities, including, but not limited to patient safety work product, Medication Variances, Infection Surveillance, Safety Surveillance, Staff Perceptions of and suggestions for improving patient safety, Staff willingness to report errors (Employee Surveys), Patient/Family perceptions of, and suggestions for improving patient safety, and results of risk assessment surveys by department.

2. The Patient Safety Committee is responsible to review and approve the organization-wide and departmental patient safety-related policies, procedures and CHS PSO information. This should include the content of any proactive risk self-assessments prior to data collection, as well as patient/family education regarding their role in helping to facilitate the safe delivery of care.

    All departments within the organization (patient care and non-patient care departments) are responsible to report patient safety occurrences, and potential occurrences to the Risk Manager, who will aggregate occurrence information and present a report to the Patient Safety Committee on a quarterly basis. This Patient Safety Work Product report will contain aggregated information related to the cause or nature of the occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, improvement actions taken, and patient outcome. The Patient Safety Committee will analyze the report information and determine further patient safety activities as appropriate. Any undesirable patterns or trends in patient safety and sentinel events should be intensively analyzed. Intense analysis involves studying a process to learn in greater detail about how it is performed or how it operates, how it can malfunction, and how errors occur.

3. Patient complaints and concerns or ideas about patient safety should be reported to and evaluated by the Patient Safety Committee. Patient safety information input regarding employee willingness to report and related information from patient and employee surveys should be reviewed and evaluated by the Patient Safety Committee. (Resolution of individual patient complaints is handled by the personnel so designated by the organization.)

4. The Patient Safety Committee reviews alerts or guidance from external sources, including TJC, Institute for Safe Medication Practices, the Food and Drug Administration and consider whether their recommendations should and could be implemented at the organization as a proactive measure to reduce patient safety risks.

5. Patient safety occurrences requiring a report to an external agency such the F.D.A., Board of Pharmacy, Center for Medicare Administration, a manufacturer or the state department of health, should also be reported to the Patient Safety Committee. This report should include an analysis of the occurrence as to underlying causes, any improvement actions recommended and/or taken and, when available, the results of those improvement actions.

6. Through review of internal data reports and reports from external sources (including TJC sentinel event report information, and other sources such as available occurrence reporting information from state and federal sources and current literature), and through the Quality Improvement priority criteria grid, the Patient Safety Committee will select at least one high-risk safety process for proactive risk assessment annually using a Failure Mode Effects Analysis methodology.

The proactive risk assessment will include:

- Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation (failure mode). For each identified failure mode, identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be (criticality);
- For the most critical effects, conduct a root cause analysis to determine why the variation (failure mode) leading to that effect may occur;
- Redesign the process and/or underlying systems to minimize the risk of that failure mode or to protect patients from the effects of that failure mode;
- Test and implement the redesigned process;
- Identify and implement measures of the effectiveness of the redesigned process; and
- Implement a strategy for maintaining the effectiveness of the redesigned process over time.

Organization-wide activities:

1. Education regarding employee responsibilities for patient safety is included in initial and annual orientation programs, both by the Risk Manager and

department manager. This includes reporting requirements and mechanisms. As appropriate, training which incorporates methods of team training to foster an interdisciplinary, collaborative approach to patient care delivery is provided. The Patient Safety Committee and other committees may recommend education as a patient safety improvement activity at any time throughout the year. Training on failure mode analysis, effects and criticality analysis should be done for those involved with this risk reduction tool.

2. Patient safety is included as a regular agenda item for at least the clinical and support service departments of the organization. The intent is to foster a culture of "patient safety as job number one", "Safety First". Patient safety is a high priority function in the design and redesign of processes, functions and systems that impact or involve patient care.

3. At any given time, the performance of critical steps in at least one high-risk process is the subject of ongoing measurement and periodic analysis to determine the degree of variation from intended performance.

4. Initiate and comply with TJC National Patient Safety Goals, and/or other regulatory or accrediting standards, by implementing the goals' elements of performance to improve Patient Safety.

Actions upon Error or Event:

Upon identification of a medical/health care error/event, the patient care provider should:

- As appropriate to the occurrence, perform healthcare interventions to contain the risk to the patient or others
- Contact the patient's attending physician and other physicians, as appropriate, to report the error or event, carrying out physician orders as necessary.
- Contact the patient's family, guardian, Power of Attorney or significant other to make aware of the error or event. Refer to the Disclosure of Treatment Outcomes policy.
- Preserve any information (Preservation Checklist) related to the error or event (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an Event Report, and in the medical record *as appropriate* to organizational policy and procedure.
- Report the medical/health care error to the staff member's immediate supervisor.
- Submit the Event Report to the Risk Manager per the Patient Safety Evaluation System.

Individuals in any department identifying a potential patient safety issue should notify their supervisor and document the findings on an Event Report. This Patient Safety Work Product includes patient safety near misses. The Event Report should be submitted to the Risk Manager per organizational policy.

Staff response to medical/health care occurrences is dependent upon the type of occurrence identified:

- Hazardous Condition/Patient Safety Issue - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue should notify their supervisor and document the findings on an Event Report form. The Event Report form will be submitted to the Risk Manager per organizational policy

- Serious Safety Event & Sentinel Event - staff should perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure. A root cause analysis should be performed for any sentinel event and near miss as defined in the sentinel event policy and procedure.

- Near Miss – staff should report the near miss event to their immediate supervisor, describe the facts of the near miss on an event report and submit the report to the Risk Manager. A proactive risk assessment may be performed to prevent recurrence if it is determined that a recurrence poses a significant safety risk to future patients. This may be determined by the Risk Manager and/or the Patient Safety Committee if there is any disagreement as to risk potential.

An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, it is the intent of this organization to adopt a non-punitive approach in its management of errors and occurrences. All personnel are *required* to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relation to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members.

Staff Support:

Staff members involved in a sentinel event occurrence will receive support from the Risk Manager regarding the staff member's professional and emotional reconciliation of the sentinel event. The staff member's involvement in the root cause analysis and action plan processes is encouraged, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the hospital's social worker, psychologist or psychiatrist on staff and/or their department supervisor.

Disclosure:

Patients, and when appropriate, their families are informed regarding the unanticipated outcomes of care, or when the outcomes differ significantly from the anticipated outcomes. The Patient Safety Committee will monitor for compliance with this standard through the information management function of record reviews, and through reports from the Patient Safety Officer of evidence found upon individual record review for other risk management purposes. (See also policy regarding disclosure of unanticipated outcomes.)

Communication:

1. Medical/health care errors and occurrences, including sentinel events, will be reported to the CHS PSO, LLC and externally, per hospital policy through the channels established by this plan. External reporting will be performed in accordance with state, federal and regulatory body rules, laws and requirements (i.e., regarding medical devices in accordance with the Safe Medical Devices Act.).

2. A quarterly report will be compiled by the Patient Safety Committee and forwarded to the Quality Improvement Council, the Medical Executive Committee and on to the governing board. An annual summary report shall also be completed and sent through the same reporting and communication channels.

3. This report shall include at least aggregate data regarding patient safety, an analysis thereof (conclusions), recommendations and actions taken to improve patient safety, both in response to actual occurrences and proactively. These reports shall be protected to the extent allowable under the disclosure laws applicable to peer review, the Quality Improvement Council, and risk management.

4. The governing board, upon evaluation of received reports (at a minimum, annually), should assess the allocation of resources, the assignment of personnel and their time, the provision of information services and data management processes, and staff training in terms of adequacy of their allocation of human, information, physical and financial resources to support patient safety improvement priorities.

Patient and Family Education:

The organization urges patients and families to get involved in their care. Educational efforts to increase consumer awareness and involvement are supported by the Centers for Medicare and Medicaid Services and TJC as a critical process to improve patient safety.   The organization encourages patients and families to:
- Speak up if they have questions or concerns, and if they don't understand, ask again. Encouraging patients that it is their right to know
- Pay attention to the care received. Making sure you are getting the right treatments and medications by the right health care professionals. Don't assume anything.

- ◆ Educate yourself about diagnosis, the medical tests you are undergoing and your treatment plan.
- ◆ Ask a trusted family member or friend to be your advocate.
- ◆ Know what medications you take and why you take them. Medication errors are the most common health care mistakes.
- ◆ And to participate in all decisions about your treatment. You are the center of the health care team.

End of Policy

Reviews:	1st	2nd	3rd	4th	5th
Date:	7/01	2/06	9/10	2/12	2/14
By:					

MONTEVISTA

Title: Safety Management Plan 2015	Policy Number: 800.101
Function: Safety Management Program	Date Developed: 7/12/99 Revised: 5/2014, 4/24/2015
Manual: Environment of Care	Page(s): 13
Developed By: Safety Committee	Attachment(s): N/A

POLICY:
Montevista Hospital (MVH) will have an active safety plan to outline operation processes designed to manage staff activities that will reduce health care errors, the risk of human injury, and provide a safe physical environment for patients, personnel and visitors.

DEFINITIONS:
1. Error - an unintentional act either of omission or commission, or an act that does not achieve its intended outcome.

2. Sentinel Event - The sentinel event applies to events that meet the following criteria:

- The event has resulted in an unanticipated death or major permanent loss of function[1], not related to the natural course of the patient's illness or underlying condition, (note: a distinction is made between an adverse outcome that is related to the natural course of the patient's illness or underlying condition [not a sentinel event] and a death or major permanent loss of function that is associated with the treatment, or lack of treatment, of that condition), or,
- The event is one of the following (even if the outcome was not death or permanent loss of function):
  - Suicide of a patient in a setting where the patient receives around-the-clock care (e.g., hospital, residential treatment center, crisis stabilization center), or
  - Infant abduction or discharge to the wrong family, or
  - Rape, the determination of which is to be based on the hospital's definition consistent with applicable law and regulation. An allegation of rape shall be investigated and the root cause analysis initiated when the determination is made that a rape has occurred, or
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities, or
  - Surgery on the wrong patient or wrong body part.

[1] A major permanent loss of function means sensory, motor, physiological, or intellectual impairment not present or admission requiring continued treatment or life-style change. When major permanent loss of function cannot be immediately determined, root cause analysis may not be initiated until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

Root Cause Analysis (RCA): An evaluation process structured to attempt to determine underlying causes of the sentinel event and whether there is a reasonable potential for process improvement to reduce the likelihood of such events in the future. The following are characteristics of a root cause analysis:

- Focus primarily on systems and processes, not individual performance;
- Progression from special causes in clinical processes to common causes in organizational processes;
- The use of "Why?" repeatedly as each reason is determined; and
- Identification of changes, if any, that should be made in systems and processes, either through redesign or development of new systems or processes, that would reduce the risk of recurrence of that sentinel event.

3. Critical Event - Critical event applies to events that meet the following criteria: The event results in or has the potential to cause serious harm or death (even if the outcome was not serious harm or death):

- Suicide of any patient other than an inpatient or who has been discharged from the facility's inpatient, partial hospitalization, outpatient or other service program within 30 days prior to the suicide, or
- Attempted suicide of any patient (that does not result in a major loss of permanent function), or
- Any actual or alleged inappropriate sexual contact between staff and current patients or individuals who are patients within two years from discharge, (to include inappropriate verbal or written communication and/or inappropriate physical contact), or
- Sexual contact between patients involving any touching of genitalia, or
- Patient elopement, or
- Staff/patient or patient/patient aggression resulting in injury to the patient, or
- Medication error resulting in injury to the patient, or
- Significant adverse drug reaction, including incidents where the correct drug and dosage were administered, yet the patient suffered a major reaction which may have precipitated a medical emergency, or
- Falls with significant injury, or
- Any other Class I Incident.

Critical Event Analysis: An evaluative process structure to attempt to determine underlying causes of the critical event and whether there is a reasonable potential for process improvement to reduce the likelihood of such events in the future. The following are characteristics of a critical event analysis:

- Focus primarily on systems and processes, not individual performance;
- Progression from special causes in clinical processes to common causes in organizational processes;
- The use of "Why?" repeatedly as each reason is determined; and
  - identification of changes, if any, that should be made is systems and processes, either through redesign or development of new systems or processes, that would reduce the risk of recurrence of that critical event.

4. Near Miss - use to describe any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of a sentinel event but outside the scope of those sentinel events which are subject to review by the Joint Commission on Accreditation of Healthcare Organizations under its Sentinel Event Policy.

5. Hazardous Condition - any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of serious adverse outcome.

6. Medication Variance – any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, or patient. Such events may be related to professional practice, pharmaceutical products, procedures, & systems, including prescribing; order communication; product labeling; packaging and nomenclature; dispensing; distribution; administration; education; monitoring; and use.

7. Adverse Drug Reactions (ADR): any undesired, unintended, excessive or exaggerated effect of a drug administered to a patient within the facility due to either the drug itself or patient idiosyncrasy (excluding gross overdose and therapeutic failure). These reactions may be expected or unexpected.

SAFETY PLAN PHILOSOPHY:

The focus of this plan is to identify and reduce risks to patient safety and employee safety. The hospital environment is one, which values the highest standards of quality and ethics integrity. Open communication and safety reporting is encouraged and a nonpunitive philosophy presides, focusing on systems and processes rather than individual blame. Individuals involved in a risk event (staff, visitor, patient, family) will be offered an opportunity to process/express feelings in a safe and therapeutic environment.

All departments/personnel are responsible to contribute to data collection, resolution of problems and continued monitoring using the PDCA PI model of safety issues. An interdisciplinary process (formal and informal) is encouraged to enhance positive outcomes. A competent work force is paramount in maintaining a safe practice; therefore every department will develop an employee competency program which is reviewed by Human Resources.

SCOPE:

The Safety Plan includes all buildings and facilities operated by MVH Hospital (MVH) and apply to all employees, physicians, and other independent practitioners, patients and visitors. It also applies to all activities conducted by staff members off site while conducting activities required by their position at the Hospital.

The scope of the Plan entails the following operational components: safety policies and procedures, safety education and training, hazard surveillance (including product recall), employee incident reports, security program, hazardous materials and waste Plan, emergency preparedness program, quality improvement program, risk Plan, life safety Plan, medical equipment Plan, utilities Plan and medical/health care errors/factors that contribute to unanticipated patient outcomes.

GOALS:

The Safety Plan functions to create a culture of safety by maintaining a safe environment for patients, personnel, and visitors through compliance with regulations, procedures, and standards set forth by OSHA, TJC, CMS, HIPAA, National Fire Code, the City of Las Vegas Fire Marshall's office, and Standard Building Codes, as well any Professional Discipline Regulatory Agencies.

Short-term objectives of the Safety Plan will be identified annually by the Safety Committee. These will be based on annual evaluation results of the Safety Plan and unresolved safety issues.

OBJECTIVES:

The objectives of the Plan are to:

- Establish and implement operational processes which guide, monitor and/or evaluate safety management practices.

- Identify the organizational components responsible for safety management functions at MVH and delineate the relationship among these components including lines of authority, responsibility and accountability.

- Identify and resolve safety management issues that result in environmental hazards and unsafe practices with special attention to hazards related to the ages of the patients served.

- Evaluate results of actions taken by individual departments to meet safety recommendations.

- Provide at least bi-monthly reports of safety management activities to MVH Hospital Board of Trustees, Administration, and department heads, including the Director of Performance Improvement.

- Provide effective process for supervising all grounds and equipment.

- Provide processes for conducting risk assessments that evaluate the buildings, grounds, equipment, occupants, and other physical systems on patient and public safety.

- Provide processes for reporting and investigating all incidents or abnormal occurrences that involve the building, patients, staff, and visitors.

RESPONSIBILITY AND AUTHORITY:

Governing Board: Montevista Hospital Hospital Board of Trustees has the responsibility, authority, and accountability for requiring, supporting the establishment and maintenance of an effective hospital-wide Safety Plan. The Board has authorized the Chief Executive Officer the responsibility to implement a Safety Plan, which is approved annually.

Chief Executive Officer: The Chief Executive Officer (CEO) has the responsibility to provide necessary staffing and equipment for the Safety Plan; and require hospital staff participation by all departments. The CEO has authorized the Safety Officer the responsibility for development, implementation, and monitoring of the Safety Plan. The CEO and Medical Director through the Medical Executive Committee authorize the Safety Officer to intervene whenever conditions exist that pose a threat of damage to equipment or building.

Quality Council: The Quality Council monitors the effectiveness of the Safety Plan and is authorized to designate resources and priority levels to the Safety Committee's recommendations. The Quality Council approves the annual Safety Plan.

Safety Committee: The Safety Committee (also known as the EOC/Infection Control Committee) is a standing committee designed to analyze identified safety management issues and to develop recommendations for resolving them. The Safety Committee is responsible for:

- The Safety Committee will meet at least every other month with an agenda and minutes completed for each meeting.

- The Chairman of the Safety Committee will be appointed by the Chief Executive Officer.

- Review and revision of the Safety Plan policies and procedures for accuracy, completeness, and proper implementation.

- Monitoring system user training programs and directing changes as appropriate.

- Monitoring safety systems and processes as it relates to the overall quality of the patient care environment.

- Developing and monitoring Performance Standards for the Safety Plan.

- The Committee will receive on a regular basis summary reports from the following areas:

    1) Patient and visitor variances
    2) Personnel injuries and occupational illness incidents
    3) Personnel and visitor security incidents and property damage
    4) Medical equipment and utility management disruptions
    5) Hazard surveillance, product recall, fire safety, and all safety and security investigations
    6) Fire drill and emergency preparedness evaluation data
    7) Life Safety (to include all aspects of fire devices, i.e., sprinkling system, fire extinguishing systems, etc.)
    8) Performance Improvement results of monitoring and evaluation activities related to hazards and safety practices
    9) Risk Management issues related to hazards and safety practices
    10) Infection Control activities related to hazards and safety practices

The EOC/IC/Safety will make recommendations to analyze identified safety management issues and to develop and approve recommendation for solving them and to monitor the effectiveness of the changes to see if correction/improvement occurs.

The EOC/IC/Safety will receive results of the annual evaluation of the Safety Plan and revise as necessary and forward the plan to Quality Council.

Safety Officer: The Safety Officer has the responsibility to manage an ongoing hospital-wide process to collect and evaluate information about hazards and safety practices that is used to identify safety management issues to be addressed by the EOC/IC/Safety . The Safety Officer will:

- Report at least bi-monthly to the EOC/IC/Safety on findings, recommendations, actions and monitoring conducted by the Safety Department. This includes but is not limited to hazard surveillance, product recall, fire safety, incident investigation.

- Participate in hazard surveillance, product recall and incident reporting on a regular basis.

- Participate in the development of departmental and organization-wide safety policies and procedures.

- Participate in Safety education orientation program for new employees and in continuing education for all employees.

- Be a member of the EOC/IC/Safety.

- Work with appropriate staff to implement EOC/IC/Safety recommendations and to monitor effectiveness of the changes.

- Prepare bimonthly reports of safety management issues and summaries of EOC/IC/Safety activities for communication and distribution to Quality Council and the Board of Directors and designated hospital personnel.

- The Safety Officer will work with the EOC/IC/Safety , Quality Council and the PI Director to develop and monitor Performance Standards for the Safety Plan.

Performance Improvement (PI) Director: The PI Director is responsible for the planning, implementation, monitoring and evaluation of Performance Improvement clinical activities including safety and risk events as well as proactive safety improvements and risk reduction strategies. The PI Director serves as a resource for regulatory compliance and risk management consultation. The PI Director works collaboratively with the Safety Officer to establish a Safety Plan and monitor the effectiveness of the plan. (Refer to PI and Risk Management sections)

Department Heads: Department Heads are responsible for establishing departmental safety programs. Safety precautions applicable to the department will be written form either collectively or inclusive in the various job functions. Each department head is responsible for employee safety awareness/education; monitoring or compliance to safety related policies and procedures; corrections of safety deficiencies and proper reporting of safety incidents/hazardous.

Employees: Hospital employees are responsible for adhering to safety policies and procedures, reporting environmental hazards and safety incidents/variances, and making recommendations for the improvement of the Safety Plan and the overall Environment of Care.

SAFETY RISK/ERROR REDUCTION:

1. MVH recognizes that a patient has the right to a safe environment therefore the organization is committed to undertaking a proactive program to identify processes which may adversely affect patient safety or be associated with medical errors.

2. Effective reduction of errors and other factors that contribute to unintended adverse patient outcomes in our organization requires an environment in which patients, their families, and organizational staff and leaders can identify and manage actual and potential risks to patient safety. Our environment must encourage:

   a. Recognition and acknowledgement of risks to patient safety.
   b. Organizational focus on process and systems assessment and improvement related to patient risk and safety.
   c. Initiation of actions to reduce these risks.
   d. Internal reporting of what has been found and the actions taken.
   e. Minimization of individual blame or retribution for involvement in a medical error.

3. MVH has delegated oversight of our patient safety and error reduction program to Quality Council.

4.   Quality Council shall report to the Medical Executive Committee and the Medical Executive Committee will report on a regular basis to the Board of Trustees. Quality Council will on a regular basis aggregate and assess all organizational data related to adverse events; incident reports; risk management; environmental safety clinical outcome measurements; risk concerns and provide a report to the Medical Executive Committee and Board of Trustees.

5.   At least annually, Quality Council will select at least two (2) high-risk processes for proactive risk assessment and risk reduction. High-risk process selection shall be based on information published periodically by the Joint Commission or other nationally recognized sources of information on patient safety and medical errors. The processes selected for proactive risk assessment and risk reduction should include those processes known to be associated with sentinel events, significant patient risk or medical errors in other organizations.

6.   Quality Council shall oversee the development of a program to reduce medication related errors.   The medication error reduction program shall incorporate the principles of medication error reduction which have been identified by the Joint Commission and by other nationally recognized sources of patient safety and error reduction strategies. MVH recognizes medication errors as medication variances.

7.   MVH understands that inconsistency in the performance of existing organizational processes frequently leads to unanticipated and/or undesirable results.   In order to minimize risk to patient safety due to undesirable process variations, Quality Council will require ongoing monitoring to ensure that processes identified as variance prone or high risk regarding patient safety are being performed. Each year the performance of critical steps in at least two (2) processes shall be subject to ongoing measurement and analysis to determine the degree of variation from intended performance. If undesirable process variation is identified Quality Council shall refer their assessment findings to the appropriate committee or team for prioritization of a performance improvement project.

8.   Specific processes which should be considered for performance improvement prioritization. Identification of risk can occur through:

      • Self report
      • Performance Improvement reporting and trending
      • Performance Improvement Team activities
      • Proactive measurement of high risk, problem prone processes
      • Failure Mode Evaluation (including near misses)

9.   Safety risks will be categorized as Class I, II, III, IV

      • Class I Incidents: Patient event requires forwarding to Corporate Risk Management.
      • Class II Incidents: Patient event requires internal tracking and trending.
      • Class III Incidents: Visitor general liability.
      • Class IV Incidents: Worker's Compensation, employee injury or concern.

10. Quality Council will assure that knowledge-based information, including journal literature, clinical practice standards or guidelines, reference information and research data, is utilized in process design and process redesign. Quality Council shall assure that knowledge based information is used and the development of at least one (1) clinical practice guideline (Best Practice) on an annual basis.

FUNCTIONS TO BE INCLUDED IN PATIENT SAFETY AND ERROR REDUCTION COMMITTEE DUTIES

Performance Improvement

1. Establish measurable objectives for improving patient safety and reducing medical errors. Measurable objectives shall be based on the elements of patient safety and error reduction which are described in this Plan.

2. Review of all sentinel/critical events including the development of a thorough and credible root cause analysis or critical event analysis, appropriate plan of correction, and follow up plan. See Sentinel Event and Critical Event Policies and Procedures #200.12 and #200.121.

3. Review and disseminate available information about sentinel events known to occur in other health care organizations that provide services similar to MVH. This includes review of all TJC sentinel event alerts through Quality Council.

4. Assuring that prioritization is given to those events and processes most closely associated with patient safety when developing the organizational measurement program and in selecting specific improvement activities.

5. Assuring that the data which the organization considers for collection to monitor performance shall include the following:

   a. Patient, family and staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety.
   b. Staff willingness to report medical/health care errors/variances.
   c. Data about the needs, expectations, and satisfaction of individuals and organizations served. MVH will ask these groups specifically how the organization can improve patient safety.

6. Aggregating organizational information related to patient safety and medical errors to identify trends or patterns in process or outcome, which may lead to untoward patient events.

7. Assuring that when organizational process are designed or redesigned, information from other organizations related to potential risks to patient safety, including occurrence of sentinel/critical events, is reviewed and risk reduction strategies are implemented in the designed or redesigned process.

Information Management

1.   Quality Council shall work with appropriate organizational staff in developing the hospital information management needs assessment. The needs assessment shall include information regarding barriers to effective communication among caregivers. Specific attention will be directed to the processes for assuring accessibility of accurate, timely and complete verbal and written communication among caregivers and all others involved in the utilization of data (including external sources).

2.   Working collaboratively with staff to assure the medical record is audited on a regular basis to verify that all information necessary to assure patient safety and reduce medical errors is contained in the medical record in a timely manner.

3.   Development of program to assure that knowledge-based information is available to clinicians to support clinical management and decision making in a timely manner, including internet access, journal subscriptions, corporate and community networking and collaborative efforts.

Environment of Care (EOC)

1.   Aggregate and assess organizational data related to environmental issues associated with patient safety and risk.   Each of the seven (7) EOC elements have an individual management plan. These plans are reviewed annually by the EOC/IC/Safety , Quality Council, Medical Executive Committee and Board of Trustees.   Additionally, departments develop specific safety policies to promote safety practices and reduction of risk opportunities. Refer to the EOC Safety Manual.

Risk Management

1.   Provide oversight of all organizational risk management activities.

2.   Develop an organizational-wide approach to the reporting and evaluation of potential medical errors.

3.   Develop procedures for immediate response to medical errors including care of the affected patient, containment of risk to others and preservation of factual information for subsequent analysis. Refer to Addendum B.

4.   Develop systems for internal and external reporting of information relating to medical errors.

5.   Aggregation and trending of all risk management information to identify those events or processes which are associated with patient safety and/or medical errors.

6.   Develop procedures to be followed related to the notification of patients and when appropriate their families about unanticipated error outcomes or medical errors. Refer to Addendum A.

Human Resources

1.   Ensure that each staff member participates in ongoing in-service, education, and training to increase his or her knowledge of job-related aspects of patient safety.

2.   Assure that ongoing in-service and other education and training programs emphasize specific job-related aspects of patient safety. As appropriate, this training incorporates methods of team training to foster the interdisciplinary collaborative approach to the delivery of patient care and reinforces the need and ways to report medical care errors.

3.   Define a mechanism for the support of staff who are involved in medical errors or sentinel/critical events.

Patient and Family Education

1.   Work with staff in the development of programs to enhance involvement by the patient and patient's family as appropriate to his or her condition as a partner in the health care process.

2.   Oversee the development of programs to educate the patient and families about their role in helping to facilitate the safe delivery of health care.

3.   Oversee the development of programs to educate patients and families regarding their responsibility for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.

4.   Work with staff to assure that patient education programs are implemented related to safe and effective use of medications.

Safety Risk Continuum of Care

The patient and staff safety standards meet regulatory requirements throughout the continuum of care at MVH. Department Heads review standards to ensure compliance for off-campus sites and when providing community services. Safety risk identification and follow through remains intact regardless of level of care or site location.

Safety Risk Event Documentation/Notification

It is the policy of MVH that patients and, when appropriate, their families are informed about outcomes of care including unanticipated outcomes. It is the obligation of the responsible

licensed independent practitioner or his or her designee to clearly explain the outcome of any treatment or procedure to the patient and, when appropriate, to the patient's family whenever those outcomes differ significantly from anticipated outcomes. Quality Council shall institute monitoring programs to assure that information regarding unanticipated outcomes is shared with patients and, when appropriate, their families in a timely manner. Refer to Addendum A.

Risk events are to be accurately documented in the medical record. Patient and non-patient related events are to be documented using appropriate internal reporting tools. Routing of this documentation is diagramed below to ensure preservation of information to appropriate notification of key caregivers (i.e., attending physician, medical physician, therapist, etc.). To encourage accurate reporting the hospital supports the Supervisor's authority to impact changes to avoid similar risk events. This includes: time limited milieu modifications, import additional staff or modify staffing pattern, notification of vendors or other department personnel to make necessary changes.

Addendum A

The patients and family if applicable are to be informed of unanticipated outcomes by the attending physician/designee unless such information is deemed detrimental to the safety of the individual. Such a sanction requires a second opinion by a psychiatrist and administrative approval.

Patient/family notification is documented in the Progress Notes, signed by the attending physician and witness by an additional care giver attending the meeting. Should information be deemed detrimental, Risk Management is contacted and provides opportunity for the second opinion to be documented and reviewed by Administration. The approval or other direction is noted and followed accordingly.

Addendum B

Immediate response to medical errors:

- Follow communication algorithm for notification
- Provide care per policy and physician orders
- Supervisor to determine risk containment measure including
  - Staffing/personnel changes
  - Equipment replacement
  - Relocation of patients
  - Modification of processes/program
- Preservation of factual information
  - Event is to be documented immediately in Progress Notes and via Risk Management tools.
  - Equipment including videotapes, medical devices, instruments, photos are to be locked in Risk Management.
  - Event analysis is to occur within 24 hours of notification.
  - Events necessitating reporting to outside agencies (i.e., CPS, Adult Protective Services, Police, and insurance carriers) will be handled promptly and with full commitment to the governing regulations by the CEO or designee.

SUBJECT: **MEETING AGENDA** REFERENCE 4002 DEPARTMENT: HOSPIAL WIDE PAGE: 1 of 1	
APPROVED BY: _____	EFFECTIVE: 11/03 REVISED:

Patient Safety Committee Meeting Agenda

The Patient Safety Committee meets on the fourth Tuesday of each month.

Patient Safety officer: name has been removed based on NRS439.843.

Date:

Members Present:

Standard Agenda Items:
1. **Sentinel Event**
2. **Other Events**
3. **Adverse Drug Events and medication errors**
4. **Incident Reports**
5. **Equipment/ Supply issues**
6. **Root Cause Analyses Evaluation**

Old business:

New business:

Other:

SUBJECT: **EVENT INVESTIGATION**
REFERENCE 4005
DEPARTMENT: HOSPITAL   WIDE
PAGE: 1 of 1

APPROVED BY: _____   EFFECTIVE: 11/03
REVISED:

POLICY:

It is the policy of   MGGH to investigate all patient safety events that occur (actual event) or almost occurred (near miss) that caused or had the potential to cause harm to a patient.

PROCEDURE:

1. Upon notification of a patient safety event the Patient Safety Officer will review all pertinent data related to the event i.e. diagnostic testing, medication orders, medical records and interviews of the parties involved etc
2. Take any action deemed necessary at the time of the investigation
3. Form a plan to prevent recurrence of a similar event
4. In the event of a sentinel event, begin investigation immediately and take such actions necessary to ensure the safety of the patient.
5. Report the event and the results of the review, action taken, and the prevention plan to the Patient Safety Committee for their recommendations
6. The Patient Safety Officer will inform the appropriate supervisor of actions taken and the determinations of the Patient Safety Committee

SUBJECT:	**PATIENT SAFETY:**	**DEFINITIONS**		
REFERENCE 4008				
DEPARTMENT: HOSPITAL WIDE				
PAGE: 1 of 1				
APPROVED BY: _____		EFFECTIVE: 01/03		REVISED:
10/13				

POLICY:

A patient safety event is defined as any incident that occurred (actual event) or almost occurred (near miss) that caused or had the potential to cause harm to a patient and shall be reported to Patient Safety Officer via the Quality Review Report.

- Near Miss: An event or situation that could have resulted in harm to a patient but did not, either by chance or through intervention.
- Adverse Event: An occurrence associated with health care or services that may or may not result in harm to a patient. These include incidents such as medication errors and patient falls even if there is no harm or permanent damage to the patient.
- Sentinel Event: An event included in Appendix A 'Serious Reportable Events in Health Care__2001 Update: A Consensus Report. Sentinel events signal the need for immediate investigation and proactive response from MGGH.
- Facility –acquired infection: A localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the tine a patient was admitted to a medical facility including: 1. surgical site infections 2. ventilator-associated pneumonia 3. Central line-related bloodstream infections 4. Urinary tract infections

SUBJECT: **PATIENT SAFETY COMMITTEE   RESPONSIBILITIES**
REFERENCE: 4000
DEPARTMENT: HOSPITAL WIDE
PAGE: 1 of 1

APPROVED BY: _____   EFFECTIVE: 11/03
REVISED: 10/1/11

Policy:

It is the policy of MGGH to develop and implement, in consultation with the providers of health care, an internal Patient Safety Program to improve the health and safety of patients/residents who are treated at our facility.

Procedure:

1. The Patient Safety Plan at MGGH encompasses Acute care, Emergency room, surgical services, clinic and Home Maker Services and compliance with the Patient Safety Plan is mandatory.
2. Following approval of the safety plan by the Governing Body, the Medical Staff shall be notified as to the existence and requirements of the plan.

3. The Patient Safety Committee is comprised of a physician, a nurse from SNF, pharmacist, governing board member, risk manager, Infection Control Officer, Patient Safety Officer, and the Administrator

The Committee shall:

- Function under the authority of the Medical Staff
- Submit its patient safety plan to the Governing Board
- Meet monthly
- Investigate, report and formulate corrective actions related to alleged sentinel events
- Review Medical Equipment/devices safety and maintenance inspections
- Review and recommend actions related to medications events
- Review and investigate patient care related incident reports
- Additional tasks as assigned by the Medical Staff

3. **The Administrator shall appoint a Patient Safety Officer with the following responsibilities:**

- Serve on the Patient Safety Committee
- Supervise the reporting of all sentinel events alleged to have occurred in the medical facility.
- Shall within 13 days of being notified of a Sentinel event or within 14 days of becoming aware without notification, report the date, time and brief description of the sentinel event to the health division, The Bureau of Licensure, Administrator and the Patient Safety Committee
- Take such actions as he/she determine necessary to ensure the safety of the patients as a result of an investigation of any sentinel event alleged to have

occurred at the medical facility

- Report to the Patient Safety Committee regarding any actions taken
- The Patient Safety Officer may designate alternates to act in his/her absence. Name has been removed (NRS439.843) RN, Risk Manager will act as Patient Safety Officer in the absence of the Patient Safety Officer
- The Patient Safety Officer is responsible to review, investigate and act upon patient safety issues other than sentinel events at this facility, including medication errors, environmental issues and equipment and supply malfunction

4. Name removed (NRS439.843) has been appointed by the Administrator as Patient Safety Officer

POLICY:
It is the policy of MGGH that all employees receive Patient Safety Training and are familiar with the job related aspects of patient safety and staff specific roles and responsibilities   to actively support patient safety

PROCEDURE:
All staff will receive patient safety education and training during their new employee orientation and on an annual and as needed basis

SUBJECT: **PATIENT SAFETY EVENT ANALYSYS**	
REFERENCE 4006	
DEPARTMENT: **HOSPITAL WIDE**	
PAGE: 1 of 1	
APPROVED BY: _____	EFFECTIVE: 11/03 REVISED:

 DEFINITIONS:

Aggregate Review Analyses: The process of   examining   data elements for common trends or patterns.

Root Cause Analyses: The process for identifying the basic or contributing factors associated with patient safety events. It identifies changes that could be made to the system to improve performance and to reduce the risk of adverse events or the recurrence of near misses with the ultimate goal of   reducing or eliminating patient harm.

POLICY:
It is the policy of MGGH to track and trend data to identify familiar trends or circumstances so that system issues can be identified and improved and to conduct a Root Cause Analyses and action plan to prevent the recurrence of   similar events

PROCEDURE:
1. The Patient Safety Committee shall collect data from each patient safety event to perform an Aggregate Review Analyses.
2. The Patient Safety Committee will conduct a root cause analyses and complete an action plan for all sentinel events focusing on system and process changes to improve performance and to reduce the risk of adverse events.
3. The Root Cause Action Plan will enumerate the risk reduction strategies, implementation, and evaluation   of the effectiveness of actions taken.
4. The Root Cause Action Plan will be submitted to the Medical Staff for approval

Safe Medical Devices Reporting to the FDA

POLICY:

It is the policy of MGGH to voluntarily report serious adverse events or product problems that are suspected to be associated with a drug or medical device to the FDA. All such events will be reported to the Patient Safety Officer and the Patient Safety Committee for review.

PROCEDURE:

The following reporting procedure will be followed

1. All adverse events or product problems will be reported to the Patient Safety Officer.
2. Department managers will be responsible for completion of the MED WATCH FDA reporting form (form 3500A)
3. The Patient Safety Officer will review and submit the completed form to
4. Forms are available in the Patient Safety Policy and Procedure manual

       FDA
         MedWatch HFD-410
         5600 Fishers Lane
         Rockville, MD 20857

POLICY: The Patient Safety Committee functions to enhance patient safety through data collection, reporting, investigation and evaluation of patient safety issues prior to an event and when an event occurs. All patient safety information will be confidential and reported through the Medical Staff Quality Assurance process.

PROCEDURE: The Patient Safety Committee shall:
- Receive reports from the Patient Safety Officer (PSO)
- Evaluate actions of the PSO in connection with all reports of sentinel events alleged to have occurred at MGGH
- Review and evaluate the quality of measures carried out to improve the safety of patients who receive treatment at MGGH
- Review and evaluate the quality of measures carried out by MGGH to prevent and control infections
- Make recommendations to the Governing Board of MGGH to reduce the number and severity of sentinel events and infections that occur at MGGH
- Monitor and document the effectiveness of the patient identification policy
- At least annually, review the patient safety checklists and patient safety policies appropriate for adoption for use by MGGH
- Revise a patient safety checklist and patient safety policy as necessary to ensuer that the checklist or policy reflects the most current standards in patient safety protocols
- On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care with information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted in #3 above
- Forward Patient Safety Committee minutes/reports to the Medical Staff quarterly. Minutes will summarize MGGH patient safety activities.
- Report on a quarterly basis to the Governing Body of MGGH regarding:

  1. The number of sentinel events that occurred at MGGH during the preceding calendar quarter
  2. The number and severity of infections that occurred at MGGH during the preceding calendar quarter
  3. Any recommendations to reduce the number and severity of sentinel events and infections that occur at MGGH

PATIENT SAFETY DATA COLLECTION:
Patient safety data collection, review and reporting of the following patient safety events is a

means of providing the safest patient care possible. Data collection will begin with the completion of a Quality Review Report.

- Sentinel events
- Adverse events
- Near Misses
- Medication errors and falls
- Equipment malfunctions
- Preventive corrective interventions

POLICY:
It is the policy of   MGGH that prevention and reporting of harm to patients is the responsibility of all employees. Anyone with knowledge of an actual or patient safety event must report it.

PROCEDURE: Near Miss and Adverse Events
- Immediately notify your Department Director and complete a Quality Review Report.
- The supervisor will review and forward it to the Patient Safety Officer within 24 hours of receipt or the first work day following a week-end or holiday
- The Patient Safety Officer will review all reports and determine what specific actions are needed and forward them to Risk Management for review through the Quality Review Process
- All events will be reported to the Patient Safety Committee

SENTINEL EVENT REPORTING
Sentinel events signal the need for immediate investigation and response and any person employed by MGGH shall, within 24 hours after becoming aware that a sentinel event has occurred, notify the Patient Safety Officer of the sentinel event.

PROCEDURE:
- Immediately perform necessary health care interventions
- Notify the patient's Medical Provider and initiate all physician orders. If   necessary contain the risk to others and preserve event related material that may require further investigation
- Document the facts in the medical record using concise, factual, objective and complete details
- Notify the appropriate department director and the Patient Safety Officer who will inform the Administrator and Risk   Manager   and in the case of an intentional unsafe act that results from gross negligence or   possible criminal activity, report to   the appropriate authorities.
- The Patient Safety Officer will notify the Bureau of Licensure and the Health Department on a form to be developed by them within the prescribed time restraints.
- All Sentinel events will be reported to and investigated by the Patient Safety Committee

SUBJECT: PATIENT INFECTION NOTIFICATION	
REFERENCE # 4007	DEPARTMENT:
PAGE: 1 of 1	
APPROVED BY: _____	EFFECTIVE: 10/1/11
REVISED:	

POLICY:
It is the policy of MGGH that when a patient at our facility has an infection, the provider of health care or the designee of the provider of health care shall, as soon as practicable, but not later than 5 days after the diagnosis is confirmed, inform the patient or legal guardian or other person authorized by the patient to receive such information that the patient has an infection. Notification of the patient may be delayed only if the patient does not have a legal guardian, has not authorized any other person to receive such information and:

1. Is not capable of understanding the information
2. Is not conscious or
3. In the judgment of the provider of health care, is likely to harm himself or herself if informed about the infection

If the provider of health care or the designee of the provider of health care delays providing information about an infection, such information must be provided as soon as practicable after:

1. The patient is capable of understanding the information
2. The patient regains consciousness
3. In the judgment of the provider of health care the patient is not likely to harm himself or herself if informed about the infection or
4. A legal guardian or other person authorized to receive such information is available

PROCEDURE:
1. At admission, all patients or their legal guardian sign a Release of Protected Health Information that lists who may be given information about their health condition
2. The provider of health care will consult this list when someone other than the patient must be given information about an infection
3. The provider of health care may authorize the Infection Control Officer, Risk Manager or other RN to inform the patient, legal guardian, or another person authorized by the patient of an infection
4. Notification will be verbal and will be documented in the medical record
5. If an infection is known or determined while the patient remains at MGGH, the patient or person authorized by the patient or the legal guardian will be notified whether the infection was acquired at the facility and of the apparent source of the infection

POLICY:
Proper patient identification is required in order to prevent errors related to invasive procedures, medication administration, transfusion of blood products, and patient labeling of specimens. The use of patient identifiers improves the reliability of the patient identification process and decreases the chance of performing the wrong procedure on the wrong patient.   It is the policy of MGGH to correctly identify patients prior to any procedures and before each interaction with a health care provider/

PROCEDURE:
The use of two patient identifiers is required to confirm a patient's identity.
1. Ask all patients for their NAME and DATE OF BIRTH prior to any treatments, procedures, or medication administration.
2. Label all specimen containers with the patient labels that are generated at admission.

	Reference #1502
	Page **1** of **12**
Mountain's Edge Hospital	
SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN	Effective: 5/13/2015
DEPARTMENT: ORGANIZATIONWIDE	Revised: NA
Approval: Executive Committee ☑	Medical Executive Committee ☑	Governing Body ☑

PURPOSE:

- The purpose of the organizational Patient Safety Plan at Mountain's Edge Hospital is to improve patient safety and reduce risk to patients through an environment that encourages:

  - Integration of safety priorities into all relevant organization processes, functions, services, departments and programs

  - Recognition and acknowledgment of risks to patient safety and medical/health care errors

  - The initiation of actions to reduce these risks

  - The internal and external reporting of what has been found and the actions taken

  - A focus on processes and systems, and the reduction of process and system failures through use of failure mode effect analysis

  - Minimization of individual blame or retribution for involvement in a medical/health care error

  - Organizational learning about medical/health care errors

  - Support of the sharing of that knowledge to effect behavioral changes in itself and other healthcare organizations

- The Patient Safety Plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to potential or actual incidents; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

- As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Mountain's Edge Hospital. The Patient Safety Plan, developed by the interdisciplinary Environment of Care Committee and approved by the medical staff, Governing Body and administration, outlines the components of the organizational Patient Safety Program.

PATIENT SAFETY PROGRAM:

- Scope of Activities:

    - The scope of the Patient Safety Program includes ongoing proactive risk assessments, using internal and external knowledge and experience, to prevent error incident, maintain and improve patient safety.

        - One high-risk process shall be selected at least every 18 months and a proactive risk assessment shall be performed.

    - Patient safety incident information from aggregated data reports and individual incident reports will be reviewed by the Safety/Environment of Care Committee to prioritize organizational patient safety activity efforts. Types of patient safety or medical/health care errors included in data analysis are:

        - <u>No Harm Errors</u> - 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.

        - <u>Mild-Moderate Adverse Outcome Errors</u> - 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.

        - <u>Any Medication Error</u>

        - <u>Any Adverse Drug Reaction</u>

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SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN	Effective: 5/13/2015
DEPARTMENT: ORGANIZATIONWIDE	Revised: NA

Approval:	Executive Committee ☑	Medical Executive Committee ☑	Governing Body ☑

- <u>Any Transfusion Reaction</u>

- <u>Hazardous Condition</u> - 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.

- <u>Sentinel Event</u> - an unexpected event or incident involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. (Refer to the Sentinel Event Policy - #1507)

- <u>Near Miss</u> - any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

- <u>Hospital Acquired Conditions (HACs), (those in accordance with Mountain's Edge Hospital Scope of Services):</u>

  - Serious preventable event - object left in surgery (never event)

  - Serious preventable event - air embolism (never event)

  - Serious preventable event - blood incompatibility (never event)

  - Catheter-associated urinary tract infections

  - Pressure ulcers

  - Vascular catheter-associated infection

  - Surgical site infection - mediastinitis after coronary artery bypass graft surgery

  - Surgical site infections following certain elective procedures, including certain orthopedic surgeries and bariatric surgery

  - Patient falls (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)

- - Manifestations of poor control of blood sugar levels, such as diabetic ketoacidosis, hypoglycemic coma

  - Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures

- The scope of the Patient Safety Program encompasses the patient population, visitors, volunteers and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions of:

  - Environment of Care

  - Emergency Management

  - Human Resources

  - Infection Prevention and Control

  - Information Management

  - Leadership

  - Life Safety

  - Medication Management

  - Medical Staff

  - Nursing

  - Provision of Care, Treatment and Services

  - Performance Improvement

  - Record of Care, Treatment and Services

SUBJECT: ORGANIZATIONAL PATIENT SAFETY PLAN	Effective: 5/13/2015
DEPARTMENT: ORGANIZATIONWIDE	Revised: NA

Approval:	Executive Committee ☑	Medical Executive Committee ☑	Governing Body ☑

- - Rights and Responsibilities of the Individual

  - Waived Testing

- Methodology:

  - The Interdisciplinary Environment of Care Committee is responsible for the oversight of the Patient Safety Program. The Environment of Care Committee Chairperson will have administrative responsibility for the program, or the Environment of Care Committee may assign this responsibility to another member of the committee (such as the Performance Improvement Director or Risk Manager).

  - **All departments** within the organization (patient care and non-patient care departments) are responsible to report patient safety incidents and potential incidents to the Performance Improvement Director, who will aggregate incident information and present a report to the Environment of Care Committee on a monthly basis. The report will contain aggregated information related to type of incident, severity of incident, number/type of incidents per department, incident impact on the patient, remedial actions taken, and patient outcome. The Environment of Care Committee will analyze the report information and determine further patient safety activities as appropriate.

  - Through review of internal data reports and reports from external sources (including, but not limited to, The Joint Commission sentinel event report information, ORYX and Core Measure performance data, incident reporting information from state and federal sources and current literature), and through the performance improvement priority criteria grid, the Environment of Care Committee will select at least one high-risk safety process for proactive risk assessment annually. All elements of the high-risk safety related process will be described using work tools as necessary (i.e., flowcharts, cause and effect diagrams). The proactive risk assessment will include:

    - Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the

undesirable variation on patients, and how serious the possible effect on the patient could be

- Prioritizing the potential processes breakdowns or failures

- For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur

- Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation

- Test and implement the redesigned process

- Identify and implement measures of the effectiveness of the redesigned process

- Implement a strategy for maintaining the effectiveness of the redesigned process over time

- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organization wide program.

- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:

  - Perform necessary healthcare interventions to protect and support the patient's clinical condition.

  - As appropriate to the incident, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.

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

- Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction; preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an incident report, and in the medical record <u>as appropriate</u> to organizational policy and procedure.

- Report the process/system failure or medical/health care error to the staff member's immediate supervisor.

- Submit the incident report to the Performance Improvement Department per organizational policy.

- Any individual in any department identifying a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and document the findings on an incident report. The incident report will be submitted to the Performance Improvement Department per organizational policy.

- Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified:

  - <u>No Harm Failures or Errors</u> (including "no harm" medication errors) - staff will document appropriately in the medical record according to organizational policy, document the circumstances regarding the no harm error on an incident report form, submit the form to the Performance Improvement Department and notify their immediate supervisor.

  - <u>Mild-Moderate Adverse Outcome Failures or Errors</u> (including medication errors) - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an incident report - submitting the report to the Performance Improvement Department per organizational policy.

- **Medication Errors** - the staff member identifying a medication error (no harm and mild-moderate harm) will notify their supervisor and the Pharmacy Department of the event.

- **Adverse Drug Reaction** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an incident report, submitting the report to the Performance Improvement Department per organizational policy. Staff will also notify the Pharmacy Department.

- **Transfusion Reaction** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the Blood/Blood Component Transfusion Reaction Policy and Procedure.

- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor and document the findings on an incident report. The incident report will be submitted to the Performance Improvement Department per organizational policy.

- **Sentinel Event** - staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.

- **Near Miss** - staff will report the near miss event to his/her immediate supervisor, describe the facts of the near miss on an incident report and submit the report to the Performance Improvement Department.

- **Hospital Acquired Conditions** - staff will follow all established protocols, guidelines and policies and procedures. Staff shall complete incident reports for any breaks in technique or policy not followed.

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

  - Further remedial action activities necessary for identified incidents

  - Proactive incident reduction activities

  - Necessity and benefit of root cause analysis performance for identified incidents or proactive reduction activities

- An effective Patient Safety Program cannot exist without optimal reporting of process/system failures and medical/health care errors and incidents. Therefore, it is the intent of this institution to adopt a non-punitive approach in its management of failures, errors and incidents. All personnel are <u>required</u> to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for errors and incidents. A focus will be placed on remedial actions to <u>assist</u> rather than punish staff members, with the Environment of Care Committee and the individual staff member's department supervisor determining the appropriate course of action to prevent error recurrence.

  - <u>Sentinel Events</u> - staff members involved in a sentinel event incident will receive support from the Environment of Care and Performance Improvement Committees regarding the staff member's professional and emotional reconciliation of the sentinel event. The Environment of Care and Performance Improvement Committees encourages the staff member's involvement in the root cause analysis and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Social Service Department, Human Resources Department and/or his or her department supervisor.

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

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

- The Patient Safety Program includes implementation of the recommendations set forth by The Joint Commission, or identified alternative recommendations defined by this institution, to achieve compliance with The Joint Commission established

National Patient Safety Goals. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified National Patient Safety Goals.

- The Patient Safety Program includes a quarterly survey of patients, their families, volunteers and staff (including medical staff) opinions, needs and perceptions of risks to patients and requests suggestions for improving patient safety.

- Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Environment of Care and Performance Improvement Committees will request a report on at least a quarterly basis consisting of random record review verifying compliance with informing the patient about outcomes of care. The Environment of Care and Performance Improvement Committees will analyze error reporting data submitted through the Performance Improvement Department for evidence of this information.

- Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. The Environment of Care and Performance Improvement Committees will request a report on at least a quarterly basis consisting of random record review verifying compliance with this educational process.

- The Patient Safety Program includes consideration, at least annually, of data obtained from the organizational Information Management Needs Assessment, which includes information regarding barriers to effective communication among caregivers. The Environment of Care and Performance Improvement Committees will also request on at least a quarterly basis, a report identifying the effectiveness of the organization to provide accurate, timely, and complete verbal and written communication among care givers and all other involved in the utilization of data.

- Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. Education includes the staff member's right to report any safety or quality of care concerns to The Joint Commission. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff will be educated and trained on the provision of an interdisciplinary approach to patient care.

- Medical/health care errors and incidents, including sentinel events, will be reported internally and externally, per hospital policy and through the channels established by this plan. External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements.

- Lessons learned from a root cause analysis shall be communicated to staff who provide services or are affected by a patient safety incident. Education shall take place through the Education Department.

- Patient safety reports from the Environment of Care Committee will be submitted to the organizational Performance Improvement Committee, which exists as the oversight committee for the Environment of Care Committee. A monthly data report and recordings of meeting minutes will be forwarded to the Performance Improvement Committee, with all information submitted held under the auspices of the Performance Improvement Committee.

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

  - All system or process failures

  - Number and type of sentinel events

  - If patients and families were informed of the adverse events

  - All actions taken to improve safety, both proactively and in response to actual incidents

REFERENCE:

CMS Improves Patient Safety for Medicare and Medicaid by Addressing Never Events, August 4, 2008,
http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3224&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

MOUNTAINVIEW HOSPITAL

PATIENT SAFETY PLAN

CY 2016

CY 2016 Patient Safety Program
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CY 2016 Patient Safety Program

I.   <u>**Introduction**</u>

Purpose, Scope and Responsibility

- ✓ Purpose:
  - o To define the essential components of the Patient Safety Program at MountainView Hospital, which is committed to ensuring a safe environment and reliable care processes.
  - o To cultivate a culture of patient safety through the ongoing promotion of a safe practices and personal accountability.
- ✓ Scope: Patient safety is everyone's responsibility. The MountainView Hospital Patient Safety Program covers all activities and functions relating to patient safety at all sites and services within the organization.
- ✓ Responsibility: Leaders, employees, members of the medical staff, students and volunteers are to be familiar with and involved in the Patient Safety Program.

Participation in Patient Safety Organization

- ✓ MountainView Hospital is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided to the Hospital. To further this objective, the Hospital contracted with HCA Patient Safety Organization, LLC ("HCA PSO, LLC"), a federally certified Patient Safety Organization ("PSO"), to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.

  Generally speaking, patient safety work product ("PSWP") is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act ("FOIA"), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act ("PSQIA") and its associated regulations. *(See 42 CFR § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.)*

  The Hospital will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses, patient safety communications, quality reviews, and other documents aimed at improving patient safety. Documents will be submitted in a standardized format to allow for comparison with like providers. As part of this effort, the Hospital will operate a Patient Safety Evaluation System ("PSES") designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC. The PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes. Designated Hospital personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

Definition of Terms

<u>Accountability</u>:   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.

Hazardous condition: Any set of circumstances (exclusive of the disease or condition in which the patient is being treated), which significantly increases the likelihood of serious adverse outcome.

Healthcare FMEA: Healthcare Failure Mode and Effects Analysis: A proactive model for addressing potential risks within the organization.

Human Error: An unintended act, or failure to act, that results in actual or potential patient injury, harm or adverse event in the process of care delivery.

Near miss: Any process variation that did not affect the patient outcome, but for which a recurrence carries a significant chance of serious adverse outcome.

Non-punitive: No punishment or disciplinary action imposed for specific error.

Patient injury: Major permanent loss of function, sensory, motor, or intellectual impairment not present at admission, requiring continued treatment or lifestyle change. When "major permanent loss of function" cannot be immediately determined, patient injury is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

Patient safety event: All adverse events or potential adverse events that are deemed preventable and Healthcare associated infections as defined by the CDC that are deemed to be preventable.

PSQIA The Patient Safety and Quality Improvement Act (PSQIA) of 2005, Pub. L. 109-41, 42 U.S.C. 299b-21-b-26 (for which the final rule implementing the regulations became effective on January 19, 2009), was enacted in response to growing concern about patient safety in the United States and the Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System*. The goal of the Act is to improve patient safety by encouraging voluntary and confidential reporting of events that adversely affect patients.

<u>PSO</u>	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.
<u>PSES</u>	A Patient Safety Evaluation System (PSES) means the collection, management, or analysis of information for reporting to or by a PSO.
<u>PSWP</u>	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:	An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function (TJC, 2011). (A permanent loss of function related to the natural course of the patient's illness or underlying condition is not a Sentinel Event.) The State of Nevada defines a sentinel event as an event included in Appendix A of "Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report," published by the National Quality Forum (Nevada Revised Statutes NRS §439.830 – effective October 1, 2013).
Sentinel Event Alert Gap Analysis:	A model for prioritizing and addressing potential risks related to publish external sentinel or warning alerts.
Unusual Occurrence:	Any event or condition not consistent with the normal or usual operation of the hospital or department and which has the potential for causing patient or visitor injury or property damage. (See policies – RM19: Sentinel Event and RM13: Disclosure of Adverse Events).

II.   Policy

The Board of Trustees delegates responsibility for oversight of the patient safety program to the Patient Safety Committee. The Patient Safety Committee monitors and evaluates the effectiveness of the Patient Safety Program and generates feedback and actions as appropriate. The Patient Safety Committee prepares an annual report to the Quality Council, Medical Executive Committee (MEC), and the Board of Trustees (BOT). The report includes at a minimum, occurrence or trending of patient safety indicators and actions taken in response to actual occurrences as well as proactive assessments of high-risk activities. The Environment of Care Committee oversees non-clinical safety related processes and system issues that affect patients, employees, and visitors in the environment of care.

Risk Management maintains the hospital-wide occurrence reporting system for patients, employees, and visitor occurrences and a referral system for hospital staff and physicians to report potential claims. Risk Management in conjunction with Hospital Quality and Patient Safety Leaders investigate actual and potential safety risk within the organization. They also evaluate occurrences to identify those that may require immediate follow up actions or meet the Sentinel Event, the Safe Medical Device Act, or regulatory agency reporting criteria, including CMS, FDA, OSHA, State of Nevada DHHS, or Joint Commission. Notification is

made to Administration, Risk Management, appropriate regulatory and accrediting agencies, equipment manufacturers and other appropriate individuals as necessary.

The Organization ensures timely coordination and dissemination of reporting and data management of patient safety information at the appropriate medical staff/organizational committees for review and discussion.

III.   <u>**Culture of Safety**</u>

MountainView Hospital is committed to creating a culture of safety by designing or redesigning systems and processes geared to prevent, detect, and minimize the hazards and likelihood of error. MountainView Hospital is focused on prevention, not blaming individuals. Patient safety events are viewed as an opportunity to learn. The Hospital believes in balancing the organization's accountability and the individual's accountability for assuring safe practices and a safe environment to care for patients.

IV.   <u>**Structure, Roles and Responsibilities**</u>

The philosophy guiding the promotion of a culture of patient safety is accountability. To achieve a culture of patient safety the following accountabilities are expected at MountainView Hospital:

Role	*Accountability*	*Specific Tasks*
Board of Trustees, with Senior Leadership	Set goals, monitor performance & require accountability.	• Receive regular and thorough reports on patient safety risks, hazards and progress towards performance improvement objectives from the MEC and Patient Safety Committee. • Receive regular and thorough briefings regarding the results of culture measurement and performance improvement initiatives • Require multi-cause analysis of errors that lead to injury. • Set performance improvement goals for safety improvement. • Hold hospital leaders accountable for achieving the integrated patient safety agenda. • Receive systematic and regular assessment of resource and budget allocations to key systems (patient safety systems, human resources, quality systems, technology) related to the patient safety agenda.

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Role	Accountability	Specific Tasks
Administrative (CEO, COO, CNO, VP's, Directors, & Physician Leaders)	Set the agenda for the rest of the team	• Ensure that an integrated patient safety program is implemented throughout the hospital. • Set performance improvement priorities and identify how the hospital adjusts priorities in response to unusual or urgent events. • Allocate adequate resources for measuring, assessing and improving the hospital's performance and improving patient safety. • Measure and assess the effectiveness of the performance improvement and safety improvement activities. • Monitor implementation for of corrective action of patient safety events. • Ensure remedial activities, identified through analysis of reported patient safety events, are implemented, effective, and do not cause unintended adverse consequences. • Develop a proactive approach to reducing errors. • Encourage an environment of openness & collaboration. • Support a dialogue about outcomes between patients and clinicians including systems to obtain direct feedback from patients regarding performance of the organization • Educate staff about safety. • Support staff and lead by example.
Patient Safety Officer / (Chief of Staff)	Lead patient safety initiatives with the medical staff and organizational staff	• Lead an integrated patient safety program. • Serve as the primary point of contact for questions about patient safety, and coordinate patient safety for education and deployment of system changes. • Execute performance improvement priorities and adjusts priorities in response to unusual or urgent events. • Assure effectiveness in measuring, assessing and improving the hospital's performance and improving patient safety. • Lead a proactive approach to reducing errors and make recommendation to reduce patient safety events. • Lead in an environment of openness & collaboration. • Assure dialogue about patient safety issues occurs effectively between patients and clinicians. • Report progress regularly, and educate about patient safety • Support staff and lead by example.

Role	Accountability	Specific Tasks
Patient Safety Coordinators	Day to day coordination and facilitation of safety initiatives	• Implement operational aspects of the patient safety program throughout the hospital. • Implement proactive patient safety management that assures immediate, appropriate response to unusual or urgent events. • Participate in measuring, assessing and improving the hospital's performance and improving patient safety. • Be accountable for patient safety initiatives and strengthening a culture of safety in day to day practice. • Support an environment of openness & collaboration. • Support a dialogue about patient safety issues between patients and clinicians. • Report progress regularly, and educate about patient safety. • Support staff and lead by example.
Pharmacists	Ensure safe medication usage	• Ensure that authoritative, up-to-date drug information is available in reference form in patient care areas and prescribers' offices. • Periodically examine all drug products stored in patient care areas and procedures on drug storage/distribution to patient care areas. • Minimize the need for nurses to calculate, manipulate, or mix medications. • Establish a pharmacy led interdisciplinary team to spearhead medication safety activities. • Provide leadership to develop safe medication delivery systems.
Clinicians & Medical Staff	Monitor, report, & learn.	• Medical staff and other employee job descriptions and competency evaluations incorporate accountability for safety. • Medical staff & employees participate in education on the importance of safety, surveillance, and expectations for reporting safety concerns, beginning with orientation. • Medical staff & employees evaluations include an individual's contributions to safety for the organization. • Medical staff & employees are positively acknowledged for disclosing errors, near-misses, and safety concerns. • Employees and physicians work collaboratively assuring responsibilities of the team to the patients are met, and noticing errors before they cause harm. • Participate in the facility reporting system for PS events, both actual and potential event.

Role	Accountability	Specific Tasks
Patients/visitors	Involved partners in prevention.	• Inform doctors and nurses about medications they take, including prescriptions, over-the-counter drugs and dietary supplements. • Ask for written information about possible side effects. • Inform the doctors and nurses about allergies & adverse reactions. • Ask a relative or friend to be an advocate. • Learn about their medical condition by asking their doctor, nurse, and other reliable sources. • Upon hospital discharge, ask doctors for an explanation of the treatment plan to be used at home. • Provide feedback regarding performance of the organization • Report safety concerns through the Patient Safety hotline and other venues available.

V. Mechanisms for Coordination

MountainView Hospital Patient Safety Committee

The MVH Patient Safety Committee (PSC) or equivalent is a multidisciplinary team involving department representatives that meets not less than monthly. The Patient Safety committee or equivalent committee, is comprised of various health care professionals including but not limited to physicians, nurses, pharmacists and administrators, and is chartered to oversee the implementation of the Hospital's Patient Safety Program. The Patient Safety Officer coordinates the PSC. The CEO, Chief of Staff, and Chair of Quality Council appoint medical leadership for the PSC.

Structures that support the Patient Safety Committee or equivalent works in conjunction with other safety committees, including but not limited to:
- Medication Safety
- Quality Council
- Environment of Care
- Falls Committee
- Infection Prevention Committee

The PSC reviews and develops implementation strategies for the NPSG's. Strategies include assessing and developing a culture of patient safety, encouraging a non-punitive reporting environment, developing a best practice infrastructure to foster the design of safety into our systems, and monitoring of systems risks and improvements. The PSC networks with other committees as appropriate per topic to gain consensus (e.g. Quality Council, Infection Prevention, Pharmacy, other). Sentinel Event Alerts and other industry alerts are routed to the appropriate committee or teams to ensure evaluation of current care processes incorporate recommended changes.

The PSC reviews Sentinel Event Alerts, other industry alerts, compliance to The Joint Commission National Patient Safety Goals, State regulatory requirements, adverse events and potential adverse events that are deemed to be preventable, health care associated infections as defined by the CDC that are deemed to be preventable, and assures recommendations are integrated into processes. Additional resources such as national and local professional organizations/associations are monitored for changes in standards and potential risk events.

Regular summary reports of progress are reported to the designated Quality Council, Medical Executive Committee, and the Board of Trustees.

The PSC reviews and approves plans to address key organizational concerns, such as Falls, Restraint Reduction, Patient/Family Education, Patient Mobility, Blood and Blood Components, Medication Safety, Adverse Drug Reactions (ADR's), Pressure Ulcer Prevalence, Health Care Associated Infections and Environmental issues updates.

The PSC recommends and provides direction for training on key initiatives and educational strategies related to patient safety.

VI.   Communicating with Patients about Safety

It is MountainView Hospital's philosophy that accountability for patient safety is imbedded in a collaborative relationship involving our Board of Trustees, administrative leadership, our medical staff, employees, patients and family.

Patient safety awareness information is posted in public areas throughout the hospital. This information contains basic strategies for patients to assist in assuring their safety. The admission and discharge patient information also contains information on the patient role in safety. Patient Guides are provided to in-patients upon admission, and includes strategies prevent untoward events such as falls, medication errors, and infections while in the hospital. Annually, Patient Safety Awareness Week activities are planned to educate and inform staff, patients and the community. The MountainView Hospital consumer web page also includes access to an electronic version of the Patient Guide. Information and additional resources are provided to assure patient involvement in their care.

Patients or their families may contact the hospital to report patient safety concerns as well as to the State of Nevada Department of Health and Human Services or to the Joint Commission. The hospital's website and other patient materials include information on how to report issues internally as well as to the Joint Commission.

Patients are randomly selected to participate in completing the Patient Experience Survey after discharge, which include questions related to the patient safety experience. These results are reported to the hospital.

VII.   Education

1. Staff Education
   - General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety
   - Specific Patient Safety Program training at orientation and annually thereafter will include:
     - An overview of the Patient Safety Program
     - Staff's role and responsibilities in the Patient Safety Program
     - Event reporting, including the events requiring reporting and the process for reporting events.
     - Methods to support and foster an interdisciplinary and collaborative approach to the delivery of patient care;
     - Examples of specific job-related aspects of patient safety.

2. Physician Education - An overview of the Patient Safety Program is provided to physicians at time of initial appointment and periodically thereafter that describes the program,

emphasizes their role and responsibilities in the program and informs them of the event reporting mechanism and Culture of Safety processes.

3. Organizational Learning: Patient safety is everyone's responsibility. Everyone has a responsibility to report. By reporting concerns, it enables the organization to learn and improve processes, procedures, and systems.

4. Lessons Learned summaries are developed to communicate lessons learned from near misses or actual events. These summaries are shared with the leadership and employees to promote organizational learning and improvement.

VIII.   Safety Improvement Activities

Prioritization of Patient Safety Activities

Prioritization elements are defined in the annual performance improvement plan and apply to patient safety initiatives. The PSC annual goals are listed at the end of this plan and meet the prioritization elements.

Routine safety-related data collection analysis
- Unusual Occurrence reporting (see policies RM21 Facility Event and Close Call Reporting, RM13: Disclosure of Adverse Events, and SPAE Guidance Policy)
- Medication Error Reporting
- Infection Surveillance
- Culture of Patient Safety Survey
- Environmental Safety Rounds and Assessment
- Patient Experience Survey
- Leadership Walk-around and Tracers
- National Patient Safety Goal Dashboard
- Annual Leapfrog (NQF Safe Practices) Survey
- Sentinel Event Alert Compliance
- Institute for Safe medication Practices(ISMP) and other industry Alerts
- Employee feedback survey

Identification, reporting, and management of patient safety events
1. To effectively improve processes and systems, health care providers should not be fearful of punishment of retribution for reporting mistakes.
2. An accessible multifaceted non-punitive, just culture reporting system exists .
3. Errors and accidents are tracked in an attempt to establish trends and patterns, to learn from them and prevent reoccurrence.
4. Healthcare providers participate in reporting and developing improved processes to effectively evaluate errors and near misses.
5. Reporting errors and near misses are a critical component of the MountainView Hospital Patient Safety Program.

The Meditech on-line incident reporting system is a tool for the documentation, investigation, and correction of patient safety issues as described in the organizational policy: RM21 Facility Event and Close Call Reporting. The Director of Risk Management coordinates this process.

Organization or Medical Staff committees refer patient safety issues to the Patient Safety Officer for review at the PSC and corrective action.

NRS 439.877 – Monitoring and Compliance

Nevada statute NRS 439.877 requires medical facilities to adopt patient safety checklists and patient safety policies. These patient safety checklists are protocols used to improve the outcomes of patients at the hospital to include:

1. Patient Discharge Process (CP120 – Discharge Planning)
2. Patient Identification Process (CP70 – Patient Identification)
3. Patient room/environment sanitation and cleaning (Sodexho 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 (CP73 – Universal Protocol / Time Out)
    b. Central Line Insertion Bundle (CP131 – Adult Central Line)

Monitoring and oversight for compliance with these policies and checklists will be the ongoing responsibility of the Patient Safety Committee.

NRS 439.865– Infection Control Program

Nevada statute NRS 439.865 requires medical facilities have an infection control program to prevent and control infections within the medical facility, as well as an infection control policy. The Hospital's Infection Control Plan is attached as an addendum to the Patient Safety Plan and is reviewed annually. (See Appendix 3 – IC19: Infection Prevention and Control Plan)

Proactive Risk Identification and Reduction:

1. Opportunities for improvement regarding patient safety issues and hazardous conditions are identified through trending of actual or potential occurrences involving patients or visitors and/or evidence-based literature (e.g. The Joint Commission Sentinel Event Alerts).
2. When an identified opportunity for improvement is identified, it is analyzed by the involved care providers according to level of severity, frequency of occurrence, potential for harm and liability.
3. At least every 18 months, one high-risk or error-prone process is selected for Failure Mode Effect Analysis (FMEA) process. The underlying systems are examined and modified or redesigned to minimize the risk of the identified failure mode.
4. Trending of adverse events, environmental safety issues, aggregate data collection, and review of intensive assessments are part of the identification and management of risks to safety and are used to prevent reoccurrences.
5. Serious unusual occurrences and sentinel events are reviewed with determination made for intensive assessment and root cause analysis according to the Facility Event and Close Call Reporting and SPAE policies.
6. Near miss events are reviewed and root cause analysis conducted as deemed appropriate.
7. Regular communication about patient safety and risk management is conducted with designated Quality Committee, Medical Executive Committee, and the Board of Trustees. Disclosure of an adverse event to a patient is in accordance withpolicy. RM13: Disclosure of Adverse Events and the SPAE policy

IX. Reporting Patient Safety Results:

To the PSC:

The Patient Safety Committee reviews and recommends actions on the following reports:
- Audits on Patient Safety
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)

- Culture of Patient Safety Survey
- Leapfrog Survey

To organization staff and medical staff:

Organizational staff receives patient safety results and information on:
- Lessons Learned summaries
- Culture of Safety Survey
- Patient experience survey results on patient safety components.
- National Patient Safety Goals and Safe Practices compliance (including accordance with NRS 439.877)
- Leapfrog Survey

To executive leadership and Board of Trustees:

The Board of Trustees and Executive Leadership receives periodic reports on:
- Culture of Safety Survey
- Leapfrog Survey
- Risk Management dashboard
- Patient Safety dashboard

X.   EVALUATION OF CY 15 PSC / Organizational Goals

GOAL	GOAL MET	GOAL NOT MET
Attain ≥ 90% compliance with NPSG / Patient Safety Audit Tool.	Goal met. Achieved >90% compliance.	
Attain 2Q15 SHARP Metric "Falls and Trauma" in green or improve by 10% from 2Q2014 results.		Goal not met. Continue to strive for green compliance and/or improvement by 10% for 2016 goals.
Decrease in labeling specimen/requisitions event reports by 10%	Goal met. Achieved 86% reduction when comparing Q42015 to Q42014.	
Attain >90% compliance with Clinical Safety Improvement Program		Goal not met. Did not achieve >90% compliance with all components of the Clinical Safety Improvement Program. For 2016, components that are continuing in the program will be separated as individual goals for more accurate tracking of compliance.
Achieve compliance with NPSG.06.01.01 – Clinical Alarm Safety. During 2015, the Hospital leadership will establish clinical alarm safety as a hospital priority and develop policy and procedure for managing clinical alarms within the organization. As a result, leadership will educate staff and LIP's about the purpose and proper		Goal partially met. A clinical alarms safety committee developed a policy and procedure for managing clinical alarms and educated staff with initial education regarding clinical alarms. For 2016, continue to make clinical alarm safety a hospital priority and expand on the work that has been started with this initiative.

operation of alarm systems for which they are responsible This will be accomplished based on the work and recommendations of an interdisciplinary team consisting of physicians, leadership, frontline staff, healthcare clinicians and Biomedical Engineering		

XI. CY 16 PSC / Organizational Goals:

1. Attain ≥ 90% compliance with NPSG/Patient Safety Audits.
2. Attain 3Q16 SHARP Metric "Falls and Trauma" in green or improve by 10% from 3Q15 results.
3. Attain 3Q16 SHARP Metric "Pressure Ulcer Stages III and IV" in green or improve by 10% from 3Q15 results.
4. Attain 3Q16 SHARP Metric "DVT and PE on All Inpatients" in green or improve by 10% from 3Q15 results.
5. Achieve compliance with NPSG.06.01.01 – Clinical Alarm Safety. During 2016, the Clinical Alarm Safety Multidisciplinary Committee will continue to review and revise processes as needed to reduce alarm fatigue. Compliance will be measured by the addition of NPSG.06.01.01 to the NPSG mandatory audits and hospital-wide tracers. Baseline compliance benchmarking will be obtained in 2016 in order to measure compliance moving forward with an expected 10% improvement in compliance from 1Q16 to 4Q16.

XI. Annual Review

The Patient Safety Program is reviewed annually and revised as necessary.   It is submitted annually for review and approval by the Medical Executive Committee and the Board of Trustees.

XII. The MountainView Hospital Patient Safety Program

The components of the patient safety program are outlined in Appendix One:

XIII. References/Authority

- The Joint Commission 2016 NPSG's
- HCA Patient Safety Organization PSO Operating Policy and Procedure
- Federal Register - Department of Health and Human Services 42 CFR Part 3 – Patient Safety and Quality Improvement

Patient Safety Program

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                    │   MountainView Hospital   │
                    │     Board of Trustees     │
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                    │  Medical Executive Committee  │
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│ Senior Management │------│ Patient Safety Officer │------│ Performance Improvement Quality │
└──────────────────┘      └──────────────────────┘      │  and Patient Safety Committees  │
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┌──────────────────┐      ┌──────────────────┐
│ Ancillary Support │      │  Patient Safety   │
│   Departments     │      │   Coordinators    │
└──────────────────┘      └──────────────────┘
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Sources of Patient Safety Data

- Proactive Risk Assessments
- FMECA's
- Surveys – Culture, Patient
- RCA's/Intensive Assessments
- Staff / Patient Safety Rounds
- Unusual Occurrence Reports
- Safety Audits: Observational, Open Record, Closed Record Reviews, Interviews
- Publications New Evidence, Event Alerts

2016 National Patient Safety Goals Overview

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)	Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
#1: Improve the accuracy of patient identification	**A: Use at least two patient identifiers when providing care, treatment or services**		
	A1 Blood draw and other lab specimen collection	Blood Bank Laboratory Nursing	Random observation audits (Quarterly)
	A2 Label containers in presence of patient	Blood Bank Laboratory Nursing	Random observation audits (Quarterly)
	B: Eliminate Transfusion Errors		
	B1. Blood transfusion process: match blood or blood component to the order; match the patient to the blood or blood component; use a two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
	B2. Qualified transfusionist part of two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
	B3. Second qualified individual part of two-person verification process	Blood Bank Laboratory Nursing	Blood Bank Audits (Quarterly)
#2: Improve the effectiveness of communication among caregivers	A. Report critical results of tests and diagnostic procedures on a timely basis.		
	A1. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.	Lab Nursing	Random charts and log audits (Quarterly)

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)		Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
#3: Improve the safety of using medications	A.	Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.	Cardiac Imaging OR Nursing	Random observations and audits, all procedure areas (Quarterly)
	B.	Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.	Pharmacy Nursing	Random chart audits (Quarterly)
	C.	Maintain and communicate accurate patient medication information.	Pharmacy Nursing	Random chart audits (Quarterly)
#6: Improve the safety of clinical alarm systems.	A.	Leaders establish alarm safety as a hospital priority.	Patient Safety Officer / PS Plan	Memorialized in PS Plan
	B.	Identify the most important alarm signals to manage. (due during 2014)	Patient Safety Committee	Clinical Alarm SafetyMultidisciplinary Committee
	C.	Establish policies and procedures for managing alarms as listed above in #B. (due 1/1/2016)	Patient Safety Committee	Clinical Alarm SafetyMultidisciplinary Committee
	D.	Educate staff and LIP's about the purpose and proper operation of alarm systems for which they are responsible. (due 1/1/2016)	Patient Safety Committee	Clinical Alarm SafetyMultidisciplinary Committee
#7: Reduce the risk of health care-associated infections	A.	Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines	Infection Prevention Nursing	Random observations (Quarterly)
	B.	Implement evidence-based practices to prevent healthcare associated infections due to multiple drug-resistant organisms (MDRO's)	Infection Prevention	MDRO Tracker (Quarterly)
	C.	Implement evidence-based practices to prevent central line-associated bloodstream infections (CLABSI's).	Infection Prevention	Targeted Surveillance (Quarterly)

The Joint Commission NPSG's	Specific Elements Within Broad Goal (Note #'s same as per The Joint Commission's NPSG's for Hospitals)	Key Content Expert Links to PSC	Audit Methodology (Cross-reference to Patient Safety Dashboard)
	D. Implement evidence-based practices to prevent surgical site infections (SSI's).	Infection Prevention	Targeted Surveillance (Quarterly)
	E. Implement evidence-based practices to prevent catheter associated urinary tract infections. (CAUTI's)	Infection Prevention	Targeted Surveillance (Quarterly)
#15: The organization identifies safety risks inherent in its patient population	A. The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]	Nursing Risk Management	(Structural process) Random chart audits (Quarterly)
Universal Protocol	A. Pre-op verification B. Site marking C. Time-out	Cardiac Medical Imaging Nursing OR	Random observations & chart audits (Quarterly)

Annual Infection Prevention and Control Program
Evaluation Year: 2015
Risk Assessment Year: 2016
IP Plan Year: 2016

MountainView Hospital
Annual Infection Prevention and Control Program

Table of Contents

I. Introduction

This document is a comprehensive evaluation, risk assessment, prevention and control plan. This process is completed annually to coincide with the MountainView Hospital fiscal year. The risk assessment is completed at least annually and whenever significant changes occur.

A. PURPOSE OF INFECTION PREVENTION AND CONTROL

The purpose of the Infection Prevention and Control Department is to minimize morbidity, mortality, and economic burden associated with health care associated infection (HAI) through prevention and control endeavors in both patient and staff populations. Using epidemiological principles, pertinent data is collected and analyzed in order to determine risk factors associated with infection and to define mechanisms of transmission and prevention. The most current CDC/NHSN surveillance definitions and comparative data base are utilized to evaluate patient outcomes. The Infection Preventionists use this information to seek opportunities for improvement; and then plans, implements, and evaluates control strategies. As a resource within MountainView Hospital and the community, the Infection Preventionists educates other professionals as well as the public about infection risks and measures to minimize and/or eliminate risks and to enhance patient safety and quality.

B. VISION STATEMENT

- Healthcare without infections

C. MISSION STATEMENT

- To create a safer environment through surveillance, prevention and control strategies in order to reduce/eliminate HAIs. The Infection Prevention and Control Program will enhance MountainView Hospital's mission of delivering high quality, cost-effective healthcare in the community.

- To empower all healthcare workers to participate in infection prevention.
- To ensure a safe environment for patients, visitors and healthcare workers.
- To provide infection prevention education.
- To promote safe quality care by implementing evidence based standards.
- To deliver high quality cost effective healthcare.

D. SCOPE OF SERVICE

Infection prevention and control is a facility-wide patient and Healthcare Workers (HCW) safety and quality improvement activity. The Infection Prevention Committee and Quality Council will determine the specific focus of surveillance, education and consultation according to hospital epidemiology and community disease surveillance system.

E. GEOGRAPHY, COMMUNITY, POPULATION, CARE, TREATMENT, AND SERVICES

This plan includes the care of inpatients, outpatients, all diagnostic areas, treatment areas and support services at MountainView Hospital. MountainView Hospital is a 340 bed acute care hospital which encompasses medical, surgical, critical care, maternal-child, intensive care, neonatal intensive care Level I-II, and rehabilitation unit. The outpatient areas include endoscopy, invasive/non-invasive diagnostic services, cardiac catheterization, outpatient rehabilitation services, outpatient radiology, outpatient wound and hyperbaric therapy

center, adult and pediatric emergency department. Construction and renovation surveillance activities are also included in the scope of services supported by Infection Prevention and Control and its Committee.

Based on estimates from the US Census Bureau (2014) Nevada has a population of 2.8 million people, Clark County has a population of 2.1 million people, not including those who are not counted due to homelessness or illegal immigration, as well as the 41+ million visitors to Las Vegas each year. This includes an ever increasing population of residents who are exposed to Tuberculosis within the community. Other significant communicable diseases based on local health department information include Invasive Haemophilus Influenza, AIDS, Chlamydia, Syphilis, Campylobacteriosis, Salmonellosis, Shigellosis, Encephalitis, Meningitis, Influenza, RSV, Measles, Pertussis, etc.

Other important geographic influences to health care delivery include:

Race/Ethnicity	2014
White	45.3%
Hispanic/Latino	30.3%
Black	11.6%
Asian/Pacific	9.9%
American Indian	1.2%
Other	1.7%

- More than 320,400 students are currently enrolled in the Clark County School District, making it the 5th largest school district in America (CCSD November 2015)
- 84.6% have graduated from high school which is below national average of 86% (US Census 2009-2013)
- 22.4% of the population has a Bachelor's degree or higher, significantly below national average of 28.8%. (US Census 2009-2013)
- Language other the English spoken at home 29.3%, significantly higher than national average of 20.7% (US Census 2009-2013)
- 56.7% of state residents own and live in houses, significantly below national average of 64.9% (US Census 2009-2013)
- Affordable Care Act was introduced in 2014 which will ensure that all Clark County Residents are insured.
- In 2010 the median age of Clark County adults was 35.5
- Leading causes of death in Clark County, Nevada (2007-2009) Heart disease, cancer, and stroke are the top three causes of death for both genders in Clark County (MyNevadaCounty.com)
- Deaths due to lower respiratory disease and accidents are the 4th and 5th leading causes locally and statewide. (MyNevadaCounty.com)
- The proportion of Clark County adults who are either overweight or obese was 33.2% male and 32.4 % female in 2011 (HealthData.org)
- Heavy drinkers 9.8% male and 7.2% female in 2012(HealthData.org)
- Binge drinking 23.5% male and 11.1% female in 2012 (HealthData.org)

- Smoking- males 24.2 % and females 22.1% smoke (HealthData.org) Overall smoking, Clark County, Nevada, is higher than the national average of 17% (CDC.gov)
- Nevada ranks poorly in health resources availability such as number of health care providers and hospital beds, insurance status and ability to pay. (SouthernNevadaHealthDistrict.org)

F. AUTHORITY AND RESPONSIBILITIES

MountainView Hospital Infection Prevention Committee with the support of the Quality Council, Medical Executive Committee and the Board of Trustees has overall authority and responsibility for the Infection Prevention and Control Program. The Infection Preventionists has primary responsibility for the daily management of infection prevention and control activities. This includes developing and implementing policies that govern control of infections and communicable diseases and developing a system for identifying, reporting, investigating and controlling infections and communicable diseases. The Infection Preventionists in conjunction with Employee Health have authority to institute any surveillance, prevention, and control measures or studies when there is reason to believe that any patient or personnel may be in danger from a potential or actual outbreak of, or exposure, to infectious disease. All employees have responsibility for adherence to infection prevention and control processes/strategies.

II. Evaluation of Effectiveness - 2015

Surveillance Activity	Goal	Intervention/ Strategy	Target(s) 2015	Outcome	Effectiveness	
					Target met	Rational
Hand Hygiene (HH) Compliance- monitored by each unit on a monthly basis.	Improve facility HH compliance overall to achieve 80 %	Provided education at orientation and annually to staff and physicians. Provide patient/family education. Identified trends from measurement outcomes. Monitored, reported, and provided effective feedback for compliance to key stakeholders at least quarterly-data is provided at each Infection Control/Prevention Committee	**MVH** 90%	2015 1st Q = 93% 2nd Q = 93% 3rd Q =95% 4th Q =97%	Met	Even though this goal was met, we will continue to place great emphasis on the importance of Hand Hygiene during 2016

Surveillance Activity	Goal	Intervention/ Strategy	Target(s) 2015	Outcome	Effectiveness	
					Target met	**Rational**
		Meeting Special "STOP" signage is provided for patients with diarrhea producing diseases, so soap and water is used for Hand Hygiene				
Preventing Central Line Associated Blood Stream Infections (CLABSI)	Facility Wide Zero	1. Well established central line bundle used in all areas performing central line insertion and maintenance. 2. Monitor report and provide effective feedback to all stakeholders monthly. 3. Hospital CLABSI rates have been shared quarterly with individual units. 4. Educate staff during nursing orientation and annually on insertion and maintenance bundles. 5. Education for patient/family on Central Lines 6. Concurrent mini RCAs were done	**NHSN** Facility rate less than 2015. SIR < 1.000 (new goal for 2016) **MVH** Facility SIR less than 2015. SIR < 1.000 (new goal for 2016)	Facility Wide 2015 Rate was 0.80 per 1000 line days MVH SIR = 1.008 NHSN SIR = 0.464	Yes	1. NHSN and MVH goals were met in 2015. 2.Continue house-wide surveillance was implemented resulting in accurate and complete analysis. 3. Due to new infection prevention team there has been improved collaboration between all MVH staff. 4. Daily rounding of patients by the leadership team. 5. Introduction of criteria for Midlines vs Central Lines

Surveillance Activity	Goal	Intervention/ Strategy	Target(s) 2015	Outcome	Effectiveness	
					Target met	**Rational**
		with nursing staff to find the root cause. 7. HAC Attack Rounds were implemented. 8. Midlines were introduced. 9. Intensivists increased their coverage to 24/7. 10. Sepsis protocol initiated. 11. Prevalence of central line dressings by Ethicon.				
Preventing Catheter Associated Urinary Tract Infections (CAUTI)	Facility Wide Zero	1. Well established Foley bundle used in all areas performing Foley insertion and maintenance. 2. Monitor report and provide effective feedback to all stakeholders monthly 3. Hospital CAUTI rates have been shared quarterly with individual units. 4. Educate staff during nursing orientation and annually on insertion, maintenance, peri and foley care 5. Concurrent mini RCAs were done with nursing	**NHSN** Facility rate less than 2015. SIR < 1.000 (new goal for 2016) **MVH** Facility rate less than 2015. SIR < 1.000 (new goal for 2016)	Facility Wide 2015 Rate: 0.41 per 1000 catheter days combined Critical Care and Med Surg Including Rehab MVH SIR= 0.254 NHSN SIR = 0.202	Yes	1. NHSN and MVH goals were met in 2015. 2. Continue house-wide surveillance was implemented resulting in accurate and complete analysis. 3. Due to new infection prevention team there has been improved collaboration between all MVH staff. 4. Daily rounding of patients by the leadership team. 5. Continue to emphasize the importance of accurate documentation of Foley use and appropriate indications.

Surveillance Activity	Goal	Intervention/ Strategy	Target(s) 2015	Outcome	Effectiveness	
					Target met	**Rational**
		staff to find the root cause 6. HAC Attack Rounds were implemented. 7. Intensivists increased their coverage to 24/7. 8. Emphasis on increasing the use of the Nurse Driven Protocol. 9. BARD education for nursing, certified nursing assistants, transporters, rehab staff, etc.				
Preventing Ventilator Associated Events (VAE)	Facility Wide Zero	1. Ventilator bundle is well established by both Respiratory and Critical Care nurses. 2. Hospital VAE rates have been reported quarterly at Infection Control Committee Meetings. 3. Educate staff during nursing orientation and annually. 4. Intensivists increased their coverage to 24/7.	**NHSN** Facility rate less than 2015. SIR – N/A **MVH** Facility rate less than 2015. SIR < - N/A	Data not available	UTA	1. NHSN and MVH goals were unable to be analyzed in 2015. 2. ICU surveillance. 3. Due to new infection prevention team there has been improved collaboration between all MVH staff. 4. Daily rounding of patients by the leadership team 5. Participation in National Group Ventilator Initiative Set up high quality Physician lead multi-disciplinary rounds Improve care coordination Use ventilator protocol Incorporate ABCDE bundle 6. Intensivist Model- synergistic initiative that championed the ventilator initiative.
Preventing Clostridium Difficle Infections (CDI) Lab ID	Facility Wide Zero	1. Proper identification of suspected or confirmed positive CDI patients. 2. CDI testing algorithm 3. Proper isolation and usage of PPE	**NHSN** Facility rate less than 2015. SIR < 1.000 (new goal for 2016)	2015 NHSN Annual SIR = 1.131	No	1 Multiple C-diff testing done after 3rd day although patient was admitted with signs and symptoms of C-diff. 2. Antibiotic Stewardship Program just starting. 3. Misunderstanding of surveillance definition. 4. Testing of inappropriate stool specimens. 5. Inappropriate ordering based

Surveillance Activity	Goal	Intervention/ Strategy	Target(s) 2015	Outcome	Effectiveness	
					Target met	**Rational**
		and hand hygiene with soap and water. 4. Encouraged HCW to decrease bio burden by utilizing bleach based wipes for daily cleaning and "high touch" areas. 5 EVS continues to use Xenex on discharges 6. Antibiotic Stewardship Program implemented. 7. C-diff Ad Hoc Committee developed. 8. HAC Attack Rounds were implemented. 9. Physician education letters sent by CMO. 10. Appropriate and timely testing. 11. Collaboration with the pathology.				on clinical judgement. 6. Review of positive C-diff showed many HO had recent antibiotic use. 7. Testing for cure.
MRSA-Bacteremia Lab ID	Facility Wide Zero	1. Continue to encourage the use of proper PPE, hand hygiene and isolation precautions on high risk patients. 2. Continue to do Active Surveillance Culturing on high risk patients. 3. ABATE Study- CHG	**NHSN** Facility rate less than 2015. SIR < 1.000 (new goal for 2016)	2015 RATE NHSN Annual SIR = 0.497	Yes	1. MNSN goal not met. 2. MVH goal met. 3. Continue to do Active Surveillance Culturing on high risk patients.

Surveillance Activity	Goal	Intervention/ Strategy	Target(s) 2015	Outcome	Effectiveness	
					Target met	**Rational**
		bathing/Mupirocin 2% nasal decolonization 4. HAC Attack Rounds				
Targeted surveillance on reportable Surgical site Infections						
NHSN Coronary Artery Bypass Grafting (CABG)	Zero	Surgical SSI rates have been reported at Infection Control Committee Meeting and Surgery Committee Meeting quarterly. Follow the SCIP protocol. MRSA nasal screening preoperatively Pharm D worked with surgical services RE: appropriate dosing/re-dosing of antibiotics. Patient education during pre-admission visit.	**NHSN-SIR < 1** **MVH** CABG SIR<1	SIR = 1.238	No	1. Goal not met. 2. Continue to follow SCIP protocol. 3. Re-emphasis use of CHG bathing, proper OR attire and proper hand hygiene. 4. Patient education RE: post op wound care and S&S of infection 5. Implemented appropriate dosing/re-dosing of antibiotics. 6. Surgical services educator to work with education department to staff education and patient education about post op and wound care
NHSN Hip Prosthesis (HPRO)	Zero	Surgical SSI rates have been reported at Infection Control Committee Meeting and Surgery Committee Meeting quarterly. Follow the SCIP	**NHSN:** ZERO **MVH** HPRO SIR< 1	SIR = 0.896	Yes	1. Goal met 2. Continue to follow current practices.

Surveillance Activity	Goal	Intervention/ Strategy	Target(s) 2015	Outcome	Effectiveness	
					Target met	Rational
		protocol. CHG Bathing MRSA nasal screening preoperatively				
NHSN Knee Prosthesis (KPRO)	Zero	Surgical SSI rates have been reported at Infection Control Committee Meeting and Surgery Committee Meeting quarterly. Follow the SCIP protocol. CHG bathing MRSA nasal screening preoperatively	**NHSN:** ZERO **MVH** KPRO SIR< 1	SIR = 0.000	Yes	1. Goal met 2. Continue to follow current practices.
NHSN Colon Procedures (COLO)	Zero	Surgical SSI rates have been reported at Infection Control Committee Meeting and Surgery Committee Meeting quarterly. Follow the SCIP protocol. CHG bathing MRSA nasal screening preoperatively	**NHSN:** ZERO **MVH** COLO SIR< 1	SIR = 0.486	Yes	1. Goal met 2. Continue to follow current practices. 3. Discussion of implementing the DUKE bundle for closures.
NHSN Abdominal Hysterectomy (HYST)	Zero	Surgical SSI rates have been reported at Infection Control Committee Meeting and Surgery Committee Meeting quarterly. Follow the	**NHSN:** ZERO **MVH** HYST SIR< 1	SIR = 0.387	Yes	1. Goal met 2. Continue to follow current practices.

Surveillance Activity	Goal	Intervention/ Strategy	Target(s) 2015	Outcome	Effectiveness	
					Target met	**Rational**
		SCIP protocol. CHG bathing MRSA nasal screening preoperatively				
NHSN Laminectomy	Zero	Surgical SSI rates have been reported at Infection Control Committee Meeting and Surgery Committee Meeting quarterly. Follow the SCIP protocol. CHG bathing MRSA nasal screening preoperatively	**NHSN: ZERO** **MVH LAM/FUSN** SIR< 1	SIR = 0.957	Yes	1. Goal met 2. Continue to follow SCIP protocol. 3. Re-emphasis use of CHG bathing, proper OR attire and proper hand hygiene. 3. Working with the Program Director of Spine and Neurosurgery to re-educate the clinic staff for pre/post op wound care
NHSN Fusion	Zero	Surgical SSI rates have been reported at Infection Control Committee Meeting and Surgery Committee Meeting quarterly. Follow the SCIP CHG bathing MRSA nasal screening preoperatively		SIR = 0.943	Yes	1. Goal met 2. Working with the Program Director of Spine and Neurosurgery to re-educate the clinic staff for pre/post op wound care
Influenza 2014-2015 Season	To have 100% of all MVH workers receive the Influenza Vaccine MVH/contractors/volunteers/students/LIP	All HCWs will have the influenza vaccine. Unvaccinated HCW will wear surgical masks while in patient care areas.	**100% of employees will be vaccinated or have a signed declination form**	88% employees vaccinated 7% declined 5% undocumented	No	1. Goal not met. 2. Miscommunication of the goal and target. 3. Goal should have been 90% MVH workers receive the Influenza Vaccine MVH/contractors/volunteers/students/LIP 4. 100% compliance with vaccination or signed declination form.

III. INFECTION PREVENTION and CONTROL RISK ASSESSMENT

YEAR: 2016

	PROBABILITY OF OCCURRENCE				PATIENT EFFECT				INTENSITY OF ORGANIZATION'S RESPONSE NEEDED TO ADDRESS THE RISK				ORGANIZATION PREPAREDNESS TO ADDRESS SUCH A RISK AT THIS TIME			RISK LEVEL
SCORE	High (3)	Med (2)	Low (1)	None (0)	Life Threat (3)	Perm Harm (2)	Temp Harm (1)	None (0)	High (3)	Med (2)	Low (1)	None (0)	Poor (3)	Fair (2)	Good (1)	Total
Geography and Community																
Flash Flooding		2			3					2					1	8
Dust Storms		2						0			1				1	4
Earthquake			1		3						1			2		7
Wildfires/smoke		2				2				2					1	7
Snowstorms			1				1				1			2		5
Breakdown of municipal services * Broken water main * Strike by sanitation employees		2					1			2					1	6
Accidents in the community: Mass transit (airplane, train, bus)		2			3					2					1	8
Bioterrorism- "Dirty Bomb"		2			3					2					1	8
Contamination of food and water supplies		2			3					2					1	8
Prevalence of disease linked with vectors, temperature, other environmental factors			1			2				2					1	6
Community																
Community Acquired MRSA	3						1				1				1	6
Community outbreaks of transmissible infectious diseases such as (Influenza, Meningitis, Norovirus and Measles)		2				2				2					1	7
Epidemic / reportable disease		2			3					2					1	8

													Total
(Pandemic Influenza)													
Disease linked to food and water contamination (Salmonella, Hepatitis A)		2			2				2			1	7
Vaccine-preventable illness in unvaccinated population		2			2				2		2		8
Vaccine shortage		2		3					3		2		10
Hospital Acquired Infection Rates													
SSI- COLO, HYST, LAM, FUSION, HPRO, KPRO CABG			1		2				2			1	6
VAE/VAP			1		2			3			2		8
CLABSI		2			2			3				1	8
CAUTI			1			1		3				1	6
C-DIFF		2			2			3			2		9
Report infections of discharged patients to other healthcare facilities	3						0			0		1	4
Receive patients from other healthcare facilities with infections	3						0	3				1	7
Resistant Organisms													
ACINETO (HA)		2				1			2			1	6
MRSA (HA)		2				1			2			1	6
VRE (HA)		2				1			2			1	6
ESBL (HA)	3					1			2			1	7
CRE (HA)		2				1			2			1	6
Severe Infectious Outbreak in the following services:													
NICU- Level I & II			1	3				3				1	8
Adult ICUs			1	3				3				1	8
Adult IMC			1	3				3				1	8
Adult Med/Surg			1		2			3				1	7
Women's Services			1		2			3				1	7
Emergency Services			1	3				3				1	8
Rehabilitation Services			1	3				3				1	8
Outpatient Services			1		2			3				1	7
Interventional Radiology			1	3				3				1	8
Surgical			1	3				3				1	8

											Total
Services											
Staff											
Hand Hygiene Non-compliance	2			1		3	2			1	9
Sharps Injuries	2				0		2			1	5
Blood/body fluid splash/exposure	2				0		2			1	5
TB Exposure	2				0		2			1	5
Exposure to communicable diseases		1		1				1		1	4
Influenza Vaccine Non-compliance		1		1				1		1	4
Non-compliance with isolation	2			1			2			1	6
Environment											
Contamination of Hospital Water		1		1			2			1	5
HD Water Purity		1	3				2			1	7
Dialysis Quality Control		1	2					1		1	5
Construction	3			1				1		1	6
Resource Limitations											
Improper cleaning or disinfection of equipment between patients		1		1			2			1	5
Improper Sterile Processing		1	2					1		1	5
N-95 Masks/PAPR		1	2					1		1	5
Gowns		1		1				1		1	4
Gloves		1		1				1		1	4
Eye Protection		1		1				1		1	4
Negative Airflow Rooms		1	2					1		1	5
Drinking Water		1		1				1		1	4
Emergency Management											
Plan for influx of infectious patients		1		1				1		1	4
Weapons of Mass Destruction (Chemical and Biological)	2		3					1	2		8
Electrical Power Outage	2			1				1		1	5

Add the assigned scores across each section to determine risk level/priority.

IV. Tuberculosis (TB) Risk Assessment

MTB Rates	2016	2015	2014	2013
Community Rate		Information not available at this time as of 12/10/15	3.3/100,000 (67 cases)	3.73/100,000 (75 cases)
State Rate		Information not available at this	2.7/100,000 (74 cases)	3.3/100,000 (92 cases)

		time as of 12/10/15		
National Rate		Information not available at this time as of 12/10/15	3.0/100,000 (9421 cases)	3.0/100,000 (9583 cases)
Facility Rate		3.8/100,000	1.0/100,000	0/100,000
# Suspected		16	Data not available	8
# Confirmed		4	1	0
Cluster of MTB		No	No	No
Employee Conversion Rates		0	1.3/1000 2/1556 employees	5.4/1000 7/1307 employees
Any group/trend with increased rate		No	No	No
Risk Classification				
# Beds	340	340	340	340
# Patients		0	0	0
Risk Assigned		Low Risk	Low Risk	Low Risk
Screening of HCW for MTB				
TB screening program	Yes	Yes	Yes	Yes
Baseline – 2 step TST, QFT or T-spot	Yes	Yes	Yes	Yes
Frequency of TST	< 365 days	< 365 days	<365 days	<365 days
Records maintained	Yes	Yes	Yes	Yes
Who maintains records	Employee Health	Employee Health	Employee Health	Employee Health
TB Infection Control Program				
Written TB Control Plan	Yes	Yes	Yes	Yes
Effective /Original Date	2/1/1996	2/1/1996	2/1/1996	2/1/1996
Reviewed/Updated	6/1/2015	5/20/2014	5/20/2014	8/25/2010
Infection Control Committee	6/1/2015	3/10/2014	3/10/2014	
Presentation of patient until collection of specimen	Variable	Variable	Variable	Variable
Specimen collection until receipt by lab	<1hr	<1hr	<1hr	<1hr
Receipt of specimen by lab until smear results are provided to healthcare provider	Within 24 hrs.	Within 24 hrs.	Within 24 hrs.	Within 24 hrs.
Admission until initiation of TB treatment	Variable	Variable	Variable	Variable
Receipt of specimen by lab until culture results are provided	6-8 weeks	6-8 weeks	6-8 weeks	6-8 weeks
Receipt of specimen by lab until drug susceptibilities are provided	Minimum of 6 weeks	Minimum of 6 weeks	Within 24 hours	Within 24 hours
Admission of patient to hospital until placement in AII precautions.	Variable	Variable	Variable	Variable
Are there lapses that need to be corrected?	Variable	Variable	Variable	Variable
Is ongoing Education provided to HCWs?	Yes	Yes	Variable	Variable
Person responsible for implementing program	Harsha Dave, RN, BSN, BSMT (ASCP), CIC	Harsha Dave, RN, BSN,BSMT (ASCP), CIC	Judith Hollett, R.N., B.S., M.S., CIC	Judith Hollett, R.N., B.S., M.S., CIC
Acid-fast bacilli smears	Contract Lab	Contract Lab	Contract Lab	Contract Lab
Culture using liquid media	Contract Lab	Contract Lab	Contract Lab	Contract Lab
Culture using solid media	Contract Lab	Contract Lab	Contract Lab	Contract Lab
Drug-susceptibility testing	Contract Lab	Contract Lab	Contract Lab	Contract Lab
Nucleic acid amplification testing	Contract Lab	Contract Lab	Contract Lab	Contract Lab
Number of AII rooms available	46	46	43	43
AII routinely checked	Yes- Refer to Plan Ops Log	Yes-Refer to Plant Ops Log	Yes-Refer to Plant Ops Log	Yes-Refer to Plant Ops Log
Directional flow checked daily on AII	Yes- Refer to Plant	Yes-Refer to Plant	Yes-Refer to Plant	Yes-Refer to Plant

rooms when in use	Ops Log	Ops Log	Ops Log	Ops Log
Process in place for annual assessment of negative pressures and air changes per hour for AIIR	Yes- Refer to Plant Ops Log	Yes-Refer to Plant Ops Log	Yes-Refer to Plant Ops Log	Yes-Refer to Plant Ops Log
Process in place for annual assessment of portable negative pressure units and/or portable HEPA filter units	No	No	Yes-Refer to Plant Ops Log	Yes-Refer to Plant Ops Log
What type of mask is used? Duckbill, Alphaprotec or PAPR	N-95	N-95	N-95	N-95
Is initial fit test completed?	Yes	Yes	Yes	Yes
Annual fit testing program in place	Yes	Yes	Yes	Yes

V. Surveillance Plan-   2016 Surveillance will become the evaluation of effectiveness

Surveillance Activity (Indicator)	Goal/Target	Actions to Reduce Risk with revisions	Patient Population	Case Finding Methodology	Data Entry	Analysis	Priority Score
Central Line-Associated Bloodstream (CLABSI) Infection NPSG.07.04.01	Zero Rate less than 2015 SIR <1.000	Central line bundle will be maintained and utilized facility wide on all central line insertions. Continue HAC Attack Rounds. Evaluation of appropriate line type (Central, PICC, Midline, PIV)	All patients with a central line	Infections will be identified through a review of cultures and clinical record.	Theradoc NHSN	Rate per 1000 device days. SIR= observed infections over expected infections based on national benchmarks.	M-1
Foley Catheter Associated Urinary Tract Infection (CAUTI) NPSG.07.06.01	Zero Rate less than 2015 SIR <1.000	Foley catheter bundle will be maintained and utilized facility wide on all Foley catheter insertions. Continue HAC Attack Rounds. Evaluation of the need for Foley catheter on insertion and daily. Accurate documentation of clinical indication for Foley.	All patients with a Foley catheter	Infections will be identified through a review of cultures and clinical record.	Theradoc NHSN	Rate per 1000 device days. SIR= observed infections over expected infections based on national benchmarks.	M-1
Ventilator Associated Events (VAE/VAP)	Zero Rate less than 2015	Vent bundle will be maintained and utilized on all ventilated patients. Continue HAC Attack Rounds. Evaluation of the need for vent on insertion and daily. Physician lead multi-	All patients on a ventilator.	Infections will be identified through a review of cultures and clinical record.	Theradoc NHSN	Rate per 1000 vent days.	M-1

Surveillance Activity (Indicator)	Goal/Target	Actions to Reduce Risk with revisions	Patient Population	Case Finding Methodology	Data Entry	Analysis	Priority Score
		disciplinary rounds Improve care coordination Use ventilator protocol Incorporate ABCDE bundle Intensivist Model in the ICU					
Surgical Site Infection rate for targeted procedures (SSI) NPSG.07.05.01	Zero SIR <1.000	SCIP protocol MRSA screening Antibiotic dosing/re-dosing. Antibiotic Stewardship Program. Appropriate hand hygiene and proper PPE Educate patients RE: SSIs Decolonization of patients with CHG bat h cloths	Targeted procedures: Colon Total Hip Total Knee Abdominal Hysterectomy CBGB Laminectomy Fusions	Re-admissions Culture results Chart review Inter-facility communication form	Theradoc NHSN	SIR < 1.000	M-1
Hospital Acquired - MRSA VRE C-Diff ESBL CRE NPSG.07.03.01	Zero To establish a baseline.	Develop evidence based practice strategies Increased education of all HCW. Educate patients who are infected or colonized with MDROs Inter-facility transfer communication form.	All	Screen "high risk" patients. Infections will be identified through a review of cultures and clinical record.	Theradoc NHSN	Rate per 10,000 patient days	M-1
Hand Hygiene NPSG.07.01.01	>80% compliance	Skills fair Staff education Secret Shoppers Empower patients and visitors to ask HCW if they have washed their hands	All	Observation	V-survey	Percent of compliance	M-1
Respiratory Plan	Annual review	Assess, Plan, Act and Implement respiratory	All	Lab test results Daily rounding	Theradoc Lawson	Annual fit testing compliance	M-1

Surveillance Activity (Indicator)	Goal/Target	Actions to Reduce Risk with revisions	Patient Population	Case Finding Methodology	Data Entry	Analysis	Priority Score
	Annual education	protocol and plan based on Evidenced Based Practices.		HCW- annual testing		Annual TST compliance Conversion rate Positive TB reported to SNHD-TB Clinic	
Infection Control Exposure Plan	Annual review Annual education	Assess, Plan, Act and Implement Infection Control Exposure Plan based on Evidenced Based Practices.	All	Exposure reporting	Lawson Corporate Risk Reduction Program	Watching for trends Evaluating against the HCA national and state benchmarks	M-1
Influenza IC.02.04.01	To have 90% of all HCW will receive the Influenza Vaccine prior to the peak of Influenza Season (Dec-Mar in our location) 100% of all HCW be compliant with vaccination or declination requirement by December 1, 2016	All HCWs will have the influenza vaccine. Unvaccinated HCW will wear surgical masks while on the clock.	All HCW	Employee Health will monitor HCW vaccination status.	Lawson NHSN	Percentage of Influenza vaccine given to HCWs.	M-1
Construction EC.02.06.05	Active participation in construction projects	ICRA's will be completed for all construction projects	ALL	Will be informed by Plant Operations prior to construction projects.	Pre-construction ICRA	Daily Infection Prevention Rounding Weekly construction meetings during large construction projects Plant Operations will let us know if any concerns arise Updates in EOC committee meeting	M-2

M=Mandated by state/CMS/HCA/OSHA
1-Highest Priority   2-Moderate Priority   3-Lowest Priority   4-Nice but not essential

VI. Processes/Strategies to Minimize, Reduce and Eliminate Infection Risk

Processes/Strategies	Description	Plan
Environmental • **Environmental Rounds** • **Dialysis Testing** • **Sterilizer Testing** • **Water system Testing**	Interdisciplinary team rounding to evaluate environmental safety and quality. Water used to prepare dialysis solutions must meet AAMI Standards for hemodialysis water quality. Sterilizing process testing is performed according to AORN, AAMI and CDC guidelines. Facility Plant Ops oversees facility waterborne pathogen prevention strategies.	Participate in interdisciplinary team rounds Continue Dialysis and Autoclave Testing per existing requirements and guidelines. Review monthly dialysis reports from Davita. Facility establishes and continues process for waterborne pathogen prevention strategies.
Construction	A pre-construction ICRA is completed with construction team prior to start of construction project. Frequent construction meetings for ongoing projects.	Follow the ICRA Monitor the construction project.
Outbreak Management	An outbreak is described as the sudden occurrence or increase of infectious and non-infectious disease and conditions. The Infection Control Program investigates potential outbreaks to identify the source and/or likely cause of infections and also investigates patients from who pathogens with high transmission potential have been identified or suspected to assure that control measures appropriate to the pathogen have been instituted. In circumstances where a significant potential for transmission of an infectious pathogen from either a patient or employee has been identified, the Infection Control Program works closely with the Employee Health Program to identify both patients and employee who may be at risk for disease acquisition and to intervene as appropriate to the circumstance.	A full scale investigation will be conducted in the event of a suspected outbreak.
Policies and Procedures	The hospital evaluates the effectiveness of its infection prevention and control plan annually and whenever the risks significantly change. Policies and procedures are written based evidence based practice.	The Infection Control Plan and Risk is reviewed annually. Policies and procedures are reviewed periodically. Changes are communicated to HCW.
Management of Sentinel Events	Cases of death or major permanent loss of function related to healthcare associated infection will be investigated/managed as sentinel events.	Potential cases will be referred to Risk Management, VP of Quality to initiate the Sentinel Event process.

Communication	Communication regarding the Infection Prevention and Control Program is ongoing. Communication between local and regional health care organizations offers opportunities for early identification of infections. Public reporting of data is accomplished monthly through NHSN	**Hospital Level – Data Provided** Leadership – Monthly Infection Prevention with leadership attendance Physicians- Quality Council and Medical Executive Committee. Staff – reports to managers responsible for sharing in staff meetings Students – IC orientation Volunteers – orientations Staff education - unit in-services, orientation, fact sheets **Community Level** Between hospitals (referring hospital will be notified when an infection is identified in transferred patient) Public Health Departments – reportable diseases Local APIC – monthly Health Department/ Hospital meetings
Education	Employees receive IC training in orientation. Employees receive education routinely, and as needed, through Healthstream learning modules. Education is provided as requested to departments related to infection prevention and control.	Evaluate the Healthstream modules for content. Staff encouraged to contact IP with questions/concerns.
Influx of Patients Effective response to a real or risk of influx of infectious patients.	There is a plan for the influx of patients to include: Staff vaccination. Education regarding isolation techniques. Maintenance of adequate store of PPE. Monitor airflow rooms for proper airflow rates and air patterns. Maintain open communication with the City, County, State and Federal Government. Follow CDC guidelines for tiered vaccine administration if there is a shortage. Participate in daily briefings as needed	Review plan every 3 years and as changes occur that may reflect need for change of the plan.

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North Vista Hospital		Saved As:	**Patient Safety Plan**
DEPARTMENTAL POLICIES AND PROCEDURES			
Subject:	**Patient Safety Plan 2016**	Formulated:	**2009**
Manual:	**ADMINISTRATION**	Reviewed:	**02/16**
Governing Board Approval	**Date:**	Revised:	**02/16**

I.   INTRODUCTION

North Vista Hospital is committed to providing quality healthcare to all patients. The Patient Safety Plan serves as a framework to establish and maintain a safe patient care environment. It expands the organization -wide support for risk management, performance improvement, information management, education, human resources and patient's rights by implementing patient safety standards, measuring and monitoring their effectiveness, and creating a "culture of safety" as part of the overall quality program.

II.   PURPOSE

Our goal is to establish a proactive approach to prevent patient injuries and other medical errors in an open and non-punitive environment. The Patient Safety Plan is to assure that a planned, systematic, coordinated approach exists to improve patient safety and reduce risk to patients through an environment that includes.

- Integration of all patient-safety activities both existing and newly created
- Focus of accountability and support within the leadership of the organization
- Patients, their families, staff and leaders in the identification and management of actual and potential risks to patient safety as well as opinions, needs and perceptions of risks to patients and suggestions for improving patient safety
- acknowledgment of risks to patient safety and medical / healthcare errors
- Initiation of actions to reduce these risks
- Internal reports of what has been found and the actions taken
- Focus on processes and systems rather than individual blame and retribution
- Ongoing proactive reduction in medical / healthcare errors
- patient safety priorities in the design and redesign of all relevant organization processes, functions and services
- Communication   to patients and when appropriate to their families about the outcomes of care, including unanticipated outcomes
- Education of patients and families about their role in helping to facilitate the safe delivery of care
- Ongoing orientation, in-service and other education and training programs to emphasize specific job-related aspects of patient safety to maintain and improve staff competence.

The Patient Safety Plan involves all departments and disciplines at all levels of North Vista Hospital in establishing the processes and mechanisms that comprise the patient safety activities through the recognition and acknowledgment of risks, preventive actions to reduce risk, internal reporting and corrective actions taken and fostering a non-punitive environment when errors occurs.

Proactive identification and management of potential risks to patient safety have the obvious advantage of *preventing* adverse occurrences, rather than simply *reacting* when they occur. This approach also avoids the barriers to understanding created by hindsight bias and the fear of disclosure, embarrassment, blame, and punishment that can arise in the wake of an actual event.

III. SCOPE OF ACTIVITIES

A. North Vista Hospital recognizes that patients, staff and visitors have the right to a safe environment. Therefore, the organization commits to undertaking a proactive approach to the identification and mitigation of medical errors through the integration into and participation of all components of the hospital into the hospital wide program. This includes Performance Improvement, Risk, Infection Control and EOC programs.

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.

IV. DEFINITIONS

Error	An unintended act, either of omission or commission, or an act that does not achieve its intended outcome. A failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems.
Patient Safety	The degree to which the risk of an intervention and risk in the care environment are reduced for a patient while under the treatment of a healthcare provider or facility.
Patient Safety Event	Any identified defect, error, medical accident, near miss, sentinel event, medication error, significant procedural variance, or other threat

Patient Safety Plan

	to safety that could result in patient injury.
Medical Accident (Error)	An unintended event in the system of care with actual or potentially negative consequences to the patient. Types of medical errors:
	▪ Diagnostic errors (misdiagnoses leading to an incorrect choice of therapy or treatment, failure to use an indicated diagnostic test, misinterpretation of test results, failure to properly act on abnormal test results)
	▪ Equipment failures (defibrillator without working batteries, or inadvertent dosing of medications in a short time frame due to IV pumps with valves that are easily dislodged)
	▪ Infections (HAI, post-op wound infections)
	▪ Blood transfusion-related injuries
	▪ Deaths due to seclusion / restraint use
Medical Accident, "near miss"	Any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. May include a clinical event.
Sentinel Event	An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would be a significant chance of serious adverse outcome.
Root Cause Analysis	A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.
Intensified Analysis	An examination of factors or elements that contribute to undesirable trends in performance to determine where best to focus changes for improvement.
Adverse Drug Event	A patient injury resulting from a medication, either because of a pharmacological reaction to a normal dose or because of a preventable adverse reaction to a drug resulting from an error.
Medication Error	Any preventable event that may cause or lead to inappropriate medication use or patient harm.
Hazardous condition	Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increased the likelihood of a serious adverse event.

V.   AUTHORITY AND RESPONSIBILITY

Governing Board
The North Vista Hospital Governing Board has the ultimate authority and responsibility for approving the patient safety program. The Governing Board has delegated the responsibility of implementing an organization-wide patient safety program and creating a **"culture of safety"** to the leaders and medical staff of the hospital.

Administrator / CNO

The Administrator / CNO is responsible for assuring that this program is implemented, supported, and evaluated throughout the organization. As such, the Administrator / CNO will establish the structures and processes necessary to accomplish this objective. The Administrator / CNO may delegate the day to day implementation and evaluation of this program to an appropriate staff member who can operationalize this plan such as the Patient Safety Officer who may be supported by the Director Performance Improvement.

Director Performance Improvement in conjunction with Patient Safety Officer

The Patient Safety Officer is responsible for the day to day implementation and evaluation of the processes and activities noted in this program. The Patient Safety Officer will work collaboratively with the Director of Performance Improvement in establishing the Patient Safety framework and a culture of patient safety. The leadership including the CNO / Administrator, Risk Manager and the Chief of Staff will provide support as needed to assure the Patient Safety Plan is fully implemented and effective in positively impacting patient safety issues.

Duties shall include:

1. Supports the PI/Patient Safety Committee by collecting and formulating relevant information to facilitate decision-making activities.
2. 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.
3. Presents Patient Safety reports to all departments.
4. Extracts and trends data from various internal and external databases, (i.e., Sentinel event alert information, Core Measure performance findings, occurrence reporting information from state and federal sources and current literature) for the use and review by the Performance Improvement/Patient Safety Committee.
5. Develops, and recommends new policies and procedures for patient safety based on analysis of data from events, and other relevant information.
6. 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.
7. Maintains the confidentiality and legal privilege, as appropriate, of all data and information.
8. Facilitates patient safety orientation and in-service education programs.
9. Utilizes the hospital's performance improvement model, to coordinate the redesign of 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. Follows critical analysis and identification of failure mode (process variation) methodology.
10. Measures and evaluates effectiveness of the patient safety program using the established goals and prepares an annual report for the Governing Board.
11. Assists department directors and administrators in enforcing policies and procedures, standards of care.

Directors and Managers

1. The leaders of the organization maintain responsibility for proper collection and dissemination of information for continuing education pertaining to the Patient Safety Program to employees.

2. The leaders create an environment that encourages prompt error identification and reduction and minimizes blame or retribution against individuals involved in an error or the reporting of an error.
3. The leaders provide direction and resources to conduct proactive correction and reversal of conditions and procedures that increase the chance that a patient might be harmed.
4. The leaders will collaborate in decision making which effects the development of hospital-wide patient care programs; policies and procedures that describe how patient care needs are met.
5. The leaders will assist in the development and implementation of the Hospital Plan for the Provision of Care, Performance Improvement Plan, Patient Safety Plan, , Information Management Plan, decision-making structures and processes; and implementation of an effective and continuous program to measure, assess and improve performance and patient safety.
6. Directors and Managers are defined as those accountable for leadership, planning, organizing, developing, controlling, directing and evaluating care for designated departments as defined in the "Provision of Care Plan".

Medical Staff
The Chief of Staff and Department Chairs of the organized medical staff through the Medical Executive Committee and in collaboration with the leaders of the organization promote and support the patient safety initiatives of Hospital.
The Medical staff is defined as those physicians, surgeons and podiatrists who have been granted recognition as members of the medical staff pursuant to the terms of the Medical Staff Bylaws.

Performance Improvement / Patient Safety Committee
The scope of the patient safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events. All departments, programs, and services within the hospital participate in the patient safety program. The hospital has an organization-wide, integrated patient safety program which operates under the PI/Patient Safety Committee. It is the responsibility of the Committee to implement a hospital-wide patient safety program. The Committee is chaired by the Patient Safety Officer who is tasked to manage the day to day operations of the patient safety program. Duties include:
1. Initiate evaluation of errors, trends, evidence-based proposals, typically ranging from no-harm, frequently occurring events to sentinel events with serious adverse outcomes.
2. Patient flow issues and the impact processes have on patient safety
3. Review and recommend approval of Patient Safety Plans
4. Review all sentinel event / root cause analyses and intensified analyses
5. Review and submit recommendations related to Sentinel Event Alerts
6. Analyze Risk Incident Occurrence and take actions to improve patient safety, in response to both actual and potential occurrences.
7. Provide annual recommendations of Patient Safety Plan
8. Recommend at least annually an area for proactive risk assessment
9. Create procedures for responding to system or process failures.

Patient Safety Plan

10. Implement and monitors the National Safety Goals compliance within the facility.

National Patient Safety Goals: 2016

Goal 1 - Improve the accuracy of patient identification.
   Use at least two patient identifiers when providing care, treatment, and services.
   Eliminate transfusion errors related to patient misidentification.
Goal 2 - Improve the effectiveness of communication among caregivers.
   Report critical results of tests and diagnostic procedures on a timely basis.
Goal 3 - Improve the safety of using medications.
   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.
   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.
   Maintain and communicate accurate patient medication information.
Goal 6 - Reduce the harm associated with clinical alarm systems.
   Improve the safety of clinical alarm systems.
Goal 7 - Reduce the risk of health care-associated infections.
   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.
   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.
   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.
   Implement evidence-based practices for preventing surgical site infections.
   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.

ADMINISTRATION MANUAL
Patient Safety Plan

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
Conduct a pre-procedure verification process.
Mark the procedure site.
A time-out is performed before the procedure.

VI. REPORTING MEDICAL / HEALTHCARE ERRORS

A. Reporting Policy
In order to achieve success in creating a safe environment for our patients, North Vista Hospital will endeavor to create an environment in which it is safe for caregivers to report and learn from errors. To promote openness, the organization shall ensure that all reported mistakes be handled without threat of punitive action. It is recognized, however, that in certain cases, disciplinary action may be necessary. The hospital recognizes that most clinical incidents result from a failure of systems. Our goal is to identify and record errors with the intent of continual process improvement. All incidents, especially clinical errors, must be reported immediately.

B. Unusual Occurrence / Risk Incident Reporting
1. Inherent in the success of any patient safety program is the accurate and timely reporting of medical / healthcare errors and occurrences. This is accomplished through the established risk management mechanism of unusual occurrence / risk incident reporting which is geared to seeking out the "why" rather than the "who".
2. The "Risk Incident Reporting" policy and procedure details the process for reporting. Reference is made to the policy and will not be detailed as part of this plan. All employees, physicians and volunteers are trained and required to report suspected or identified medical / healthcare errors.
3. When a medical / healthcare error is identified, 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 any necessary interventions to contain the risk to others
   ▪ Contact the attending physician and/or other physicians as appropriate to report the error, carrying out any physician orders as necessary, if licensed to do so
   ▪ Preserve any information related to the error, including physical information such as blood unit bags, medication vials and labels, pumps and other devices
   ▪ Complete appropriate documentation according to organizational policy in the medical record

- Complete an Risk Incident Report in addition to reporting the error to the immediate Director or Manager as appropriate
- Any Director / Manager receiving a report of a possible sentinel event or "near miss" will assure that the Director Performance Improvement and Administrator / CNO (Risk Manager) are promptly notified per the Sentinel Event Policy to determine status of the event.

4. Staff response to medical /healthcare errors are dependent on both the type of error identified and the actual or potential harm to the patient. All errors including "no harm" errors must be reported. The trending of unusual occurrence / incident reporting data over time is useful in identifying and correcting systems and processes before patient safety is compromised. Even a "no harm" error if found to be repetitive and organization-wide, will eventually result in a patient injury at some point in time if not corrected.

5. Medical / healthcare errors and occurrences will be reported internally and externally according to hospital policy and through the established mechanisms defined in such policy. Any external reporting will be initiated by the CNO/ Administrator in accordance with all state, federal and regulatory agency rules, laws and requirements.

A Health Care Worker may report a Serious Event to the State Department of Health. Before reporting a Serious Event to the State Department of Health, the HCW will ensure the event has been internally reported according to the Patient Safety Plan. A HCW who has a concern about the safety or quality of care provided in our organization can anonymously report the occurrence to the hospital patient safety officer. The HCW may also contact the DNV at 866-496-9647, or complete the Patient Complaint Report below. Alternatively, you may also fax the information at 513-947-1250.

C. Adverse (Never) Events: "Adverse (Never) event" includes any of the following:

1. SURGICAL OR INVASIVE PROCEDURE EVENTS
   o Surgery or other invasive procedure performed on the wrong site
   o Surgery or other invasive procedure performed on the wrong patient
   o Wrong surgical or other invasive procedure performed on a patient
   o Unintended retention of a foreign object in a patient after surgery or other invasive procedure
   o Intraoperative or immediately post-operative/post-procedure death in an ASA Class 1 patient

2. PRODUCT OR DEVICE EVENTS
   o Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
   o 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
   o Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

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

4. CARE MANAGEMENT EVENTS
   o 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)
   o Patient death or serious injury associated with unsafe administration of blood products
   o Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
   o (NEW) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
   o Patient death or serious injury associated with a fall while being cared for in a healthcare setting
   o Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
   o Artificial insemination with the wrong donor sperm or wrong egg
   o (NEW) Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
   o (NEW) Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. ENVIRONMENTAL EVENTS
   o Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
   o 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
   o 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
   o 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 -(NEW) 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
   o Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
   o Abduction of a patient/resident of any age

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- o Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
- o 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

An adverse event or series of adverse events that cause the <u>death or serious disability</u> of a patient, personnel, or visitor.

- The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.
- "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than <u>seven days</u> or is still present at the <u>time of discharge</u> from an inpatient health care facility, or the loss of a body part.
- Nothing in this section shall be interpreted to change or otherwise affect hospital reporting requirements regarding reportable diseases or unusual occurrences, as provided in any state or federal statute.

Please refer to Adverse Event Reporting policy for reporting Adverse Events to the Department of Public Health.

D. Sentinel Events
The established organization policy on the management of sentinel events will determine the organizational response to medical / healthcare errors and occurrences. All sentinel events and "near miss" occurrences will have a Root Cause Analysis conducted. Included in the RCA process is the identification of specific risk reduction strategies to prevent recurrence with assigned responsibilities and time frames for completion and implementation.

VII. PERFORMANCE TO ENSURE PATIENT SAFETY

A. Proactive Risk Assessment (Failure Mode and Effects Analysis). A FMEA will be conducted on at least once every 18 months on one high-risk, high / low volume or "error prone" process. 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:
- The perceptions of risk to patients and suggestions for improving care
- The level of staff reluctance to report errors in care

B. Performance measurement data will be collected, aggregated, and analyzed to determine if opportunities to improve safety and reduce risk are identified. If so, the organization will prioritize those processes that demonstrate significant variation

from desired practice, and allocate the necessary resources to mitigate the risks identified.

1. Assess the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation.
2. For each undesirable variation, identify the possible effects on patients, and how serious the possible effect on the patient could be (criticality of the effect).
3. For the most critical effects, conduct a root cause analysis to determine why the variation leading to that effect may occur.
4. Redesign the process and/or underlying systems to minimize the risk of that variation or to protect patients from the effects of that variation.
5. Test and implement the redesigned process.
6. Identify and implement measures of the effectiveness of the redesigned process.
7. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

C. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.

D. When processes, functions, or services are designed or redesigned, patient safety will be considered as part of the planning and implementation process.

E. 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).

VIII.   DATA COLLECTION AND RISK ASSESSMENT
In order to reduce the likelihood of patient incidents and negative outcomes, North Vista Hospital shall track the frequency and type of medical errors and compile them in order to learn from and prevent future negative occurrences.

A. Data Sources
  1. Internal
     - Risk incident reports with database compilation
     - Adverse Drug Events and Adverse Drug Reactions
     - Data from patient complaints
     - Risk Management and Safety findings
     - Compliance findings
     - PI and special study findings
     - Infectious Disease information
     - Operative/Invasive procedure, blood use, autopsy, restraint reviews
     - Morbidity/Mortality review findings
     - Departmental indicators
     - Employee surveys (includes perception of risk)

  2. External

Patient Safety Plan

- Sentinel Event Alerts
- Core Measures Indicators
- Accreditation / regulatory deficiencies
- Patient Satisfaction Surveys
- Other Evidence-Based external sources

B. 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).

C. 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.

D. 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.

E. PDCA (Plan, Do, Check, Act) methodology for Performance Improvement will be utilized for all performance improvement activities within the facility.

IX. **PATIENT, STAFF AND HEALTHCARE PRACTITIONER EDUCATION**
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, including providing information about their health status, and asking questions when they do not understand information provided to them.

B. Staff and HCP's will receive education and training on Patient Safety processes during their initial orientation process and annually regarding specific job-related aspects of patient safety, including the need and mechanism to report medical / healthcare errors, actual and potential adverse events and preventable healthcare associate infections. Ongoing in-service and other education provided will assist in the maintenance and improvement of staff competence and will support an interdisciplinary approach to patient care.

X. **CULTURE OF SAFETY SURVEY**
North Vista Hospital will periodically conduct a survey to assess its Culture of Safety. The Hospital Survey on Patient Safety Culture is designed to measure four overall patient safety outcomes:
- Overall perceptions of safety
- Frequency of events reported
- Number of events reported

- Overall patient safety grade

Hospital will utilize the Agency of Healthcare and Research Quality (AHRQ) research survey that is intended to measure the ten dimensions of culture pertaining to patient safety:

1. Supervisor/manager expectations & actions promoting patient safety
2. Organizational learning – continuous improvement
3. Teamwork within units
4. Communication openness
5. Feedback & communications about errors
6. Non-punitive response to error
7. Staffing effectiveness
8. Hospital management support for patient safety
9. Teamwork across hospital units
10. Hospital handoffs & transitions

The results of the survey will be used by the PI/Patient Safety Committee to enhance the patient safety program at North Vista Hospital.

XI. PLAN EVALUATION

A. This plan encompasses many disciplines and activities in addition to those specifically referenced in the plan. The Patient Safety Plan is designed to assist in the integration of these activities, not replace them. Integration should enhance the accountability and impact of the patient safety related activities and collectively provide a comprehensive patient safety management system for North Vista Hospital.

B. The Patient Safety Plan should be considered a "working" documented and an interim product to facilitate the development of a "culture of safety". As such, the plan may be modified as the implementation of the patient safety standards takes place and sections of the plan are incorporated into existing plans, policies, procedures and protocols.

C. The Patient Safety Plan will be reviewed on an annual basis. Goals shall be identified and prioritized based on internal occurrences and trends, RCA, FMEA, survey results, National Patient Safety Goals, Sentinel Event Alerts, State and Federal regulations, medication safety strategies and other applicable safety initiatives.

REFERENCES:
- Joint Commission Patient Safety Standards, Joint Commission Sentinel Event Alerts, & Sentinel Event policy
- Performance Improvement Plan
- Patient Safety Plan
- Environment of Care Plan
- Plan for Provision of Patient Care
- Occurrence / Risk Incident Reporting policy
- Applicable state statutes

Patient Safety Plan

X. CONFIDENTIALITY

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 NRS 49.625 and 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.

Effective:	*06/2002*
Approved:	*02/2016*
Last Revised:	*02/2016*
Next Review:	*02/2017*
Owner:	*Becky Sharp: Regulatory Coordinator*
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.

"Never 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. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Stage 2 or 3 pressure ulcers not present on admission
5. Falls and trauma
6. Catheter-associated urinary tract infections
7. Central line-associated blood stream infection
8. Hospital acquired infections
9. 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 is inclusive of 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, Quality Council and Patient Safety committees. 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, Quality Council and Patient Safety committees. The infection control nurse will be a member of these committees and report on his/her activities at least quarterly.

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 439.855 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.

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. PSO, Chairman

B. Chief Nursing Officer and/or Member representing the Governing Board

C. Director, Quality, Risk & Safety

D. Medical Staff member

E. Nursing Staff member

F. Member representing Pharmacy services

G. Infection Prevention and Control Practitioner

H. Facility Safety office or designated representative

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, must 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
- 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 1st of each year, the committee submits a report to the Director of the Legislative Council Bureau for transmittal to the Legislative Committee on Health Care. The report is to include information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph above outlining checklist review (NRS 439.800).
- At least once each calendar quarter, report to the Governing Board regarding:
  - ◦ The number of sentinel events that occurred at the hospital during the preceding calendar quarter; and
  - ◦ Any recommendations to reduce the number and severity of sentinel events that occur at the hospital.

REFERENCES:

TJC Standard LD.04.04.05 (2013): Patient Safety Program Components and Governing Body Report

TJC Standard LD.03.01.01 (2013): 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

---The Patient Safety Plan approval page(page 7) has been removed based on NRS439.843.

2016

COPE: **Facility-wide**

PURPOSE:
The Patient Safety Program is a hospital wide approach that is supported by all organizational leaders and staff addressing interventions to promote a culture of safety. The program will address medication safety, environmental safety, continued readiness, sentinel events, RCA and near misses, nursing sensitive indicators, interventional toolkits, and all occurrences that have the potential to cause harm to patients. The goal is to proactively assess risk in current processes and consider safety as it relates to all new processes or redesign

OBJECTIVES
The Patient Safety Program is an essential part of the hospital vision to improve the health status of its patients. In support of this commitment the Governing Board and Senior Management endorses an integrated system wide patient safety program (NRS 439.865). The objectives of this program are as follows:

1. Promote a patient-safe environment that identifies mechanisms that contribute to patient safety, such as review of high risk patient care processes, collection and analysis of adverse patient incident data, and routine investigation of significant adverse events. This environment provides for a non-punitive approach to the identification and reporting of medical errors.

2. Develop proactive patient safety risk reduction strategies for minimizing the occurrence of medical/health care errors using TJC sentinel event information and other published information related to the medical/health care errors.

3. Aggregate patient safety related data and information to improve professional and organizational performance. Encourage the dissemination of "Best Practices" through an integrated approach, which is supported by ongoing performance improvement.

4. Improve internal communication regarding actual and potential medical and healthcare errors and utilize that knowledge to improve patient safety.

RESPONSIBILITY

1. The Patient Safety Council is designated by hospital leadership and the Governing Board as the interdisciplinary group to oversee and manage the Patient Safety Program. Leadership will ensure that patient safety issues are given high priority and addressed when processes, functions, and services are designed or redesigned. Leadership will also be responsible for commissioning focus teams to develop and administer action plans. Ad hoc membership will provide a multidisciplinary approach as well as information and participation to achieve the goal of healthcare delivery in a safe environment.

2. Governing Board: The Board has the overall responsibility for insuring the delivery of quality healthcare services at NNMC. The Board delegates to the Patient Safety Council the authority for monitoring and evaluating the Patient Safety Plan. On an annual basis, the Risk Manager will report Improvement/Process activities to the Quality Oversight Committee via the Patient Safety Council and Performance Improvement Committee and ultimately the Governing Board.

3. CEO/Managing Director: The Board delegates to the Managing Director/CEO the authority and accountability for the organizational support and maintenance of the Patient Safety Plan. The CEO delegates the authority for plan design and the operational oversight to the Director of Risk Management who will also serve as the facility Patient Safety Officer.

4. Risk Management: Risk Manager, under the authority of the Managing Director/CEO is responsible for the implementation of the Patient Safety Plan. This includes the management and analysis of risks, conducting risk assessments, and evaluation of occurrences Monthly reports are provided to the Patient Safety Council as the oversight body for the Patient Safety Plan (NRS 439.870)

5. Department Managers: The department managers of each area will be responsible for identification and reporting of all circumstances (actual and potential) and processes that pose risk to patients, staff and visitors. The managers will support a non-punitive JUST Culture approach to error identification and reduction. They will provide education and assessments to reduce the risk of patient harm. The managers are responsible for initial investigation, trending, and remedial measures as well as assessing the effectiveness of the actions taken. They will work in conjunction with the risk and performance improvement plans to meet the goals of the patient safety initiatives.

6. Patient Safety Council: The council includes the Chief of Staff, CEO/Managing Director or Chief Operations Officer, Chief Nursing Officer, Director of Pharmacy, Performance Improvement Director/Manager, Infection Control Officer, and Director of Risk Management (Safety Officer). Other individuals may be called upon on an ad hoc basis for information and assistance. This committee provides the oversight for the Patient

Safety Plan. This committee as approved by the Board will provide analysis and make recommendations based on reported events or trends to ensure a safe patient environment.

DEFINITIONS

1. A "sentinel event" is defined by statute (10/2013) as an event included in the Appendix A of 'Serious Reportable Events in Healthcare' – published by the National Quality Forum. (NRS 439.830)

2. A "near miss" is defined as an unexpected occurrence in which there was no adverse outcome to the patient, but which had the potential to cause serious injury or harm to the patient.

3. A "good catch" is defined as a set of circumstances that may lead to an injury if the process is left unchanged, and the identification and report of the existence of such a condition before the event occurs.

4. "Risk Assessment" is the periodic review that is designed to assess the risks associated with the delivery of patient care in a specific setting or service.

5. "Failure Mode Effects Analysis" is a systematic methodology designed to identify and prevent process failures before they occur.

THE PATIENT SAFETY PROGRAM INCLUDES:
1. **Descriptions of mechanisms to ensure all components of the organization are integrated into and participate in the program.**
   Implementation:
   The Patient Safety Council will ensure that all departments and services of the organization are integrated into and participate in the program. Each department/service will review sentinel event alert information as it applies to that department and incorporate this information into departmental training and competency assessment. Each department/services develops strategies for approval by hospital leadership, to address the issue(s).

2. **Procedures for immediate response to medical/health care errors, including care of the affected patient(s), containment of risk to others, and preservation of the factual information for subsequent analysis.**
   Implementation:

The Serious Incidents and Root Cause Analysis Policy will be utilized for immediate response to a sentinel event or near miss. The patient(s) will be cared for following the incident according to standards of care and practice. Immediate actions will be taken, as appropriate, to minimize risk to other patients. The involved staff will be convened, according to time frames established in the Serious Incidents and Root Cause Analysis Policy, to review the incident and preserve factual information for analysis.

3. **Clear systems for internal and external reporting of information relating to medical/health care errors.**
Implementation:
If a sentinel event, medical/health care error, or near miss occurs, a Healthcare Peer Review Report (incident event) will be completed via remote data entry as soon as the event is discovered. The incident should be reported to the immediate supervisor and hospital administration. The report shall be sent to the Risk Management Department within 24 business hours. Trends and analyses will be communicated to the Safety Committee (EOC), Performance Improvement Committee, Patient Safety Council, and Governing Board.

4. **Defined mechanism for responding to various types of occurrences, such as root cause analysis in response to a sentinel event, or for conducting proactive risk reduction activities.**
Implementation:
If a sentinel event, medical/health error, or near miss occurs, a Healthcare Peer Review Report will be completed via remote data entry and reported to the immediate supervisor and hospital administration. In accordance with policy and based on core group findings, within 48 hours administration will form a PI Team to conduct a root cause analysis of the sentinel event. Proactive risk assessments will be conducted through the Patient Safety Council in response to TJC sentinel event information and internal aggregated information.

5. **Define mechanism for support of staff involved in sentinel event.**
Implementation:
When the PI Team is formed in response to a sentinel event medical/health care error, or near miss, a debriefing of the staff involved will occur. If necessary the staff may talk to someone from Human Resources and/or the Ethics Committee for additional support.

6. **Annual report to the governing body on occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.**
Implementation:

The Patient Safety Council will establish ongoing proactive patient safety monitors in response to the UHS Risk Alerts, TJC sentinel event information and recommendations from TJC in addition to other organizational alerts. All recommendations from UHS, TJC and other healthcare organizations will be considered, as appropriate to the organization's services. The recommendations, or reasonable alternatives, will be implemented, or an explanation for not implementing the recommendations will be documented. Other published information and internal aggregate information may also be considered in establishing proactive patient safety monitors. These will be monitored on an ongoing basis and reported to the Patient Safety Council, Medical Executive Committee and Governing Board at least quarterly. If actual occurrences exist, these will be included in the quarterly report, and reported to the Patient Safety Council, Medical Executive Committee, and the Governing Board on the proactive monitoring results, actual occurrences, and actions taken to improve patient safety.

7. **Proactive risk assessment activities using UHS Risk Alerts and TJC sentinel event information.**
   Implementation:
   The Patient Safety Council will establish ongoing proactive patient safety monitors in response to the UHS Risk Alerts, TJC sentinel event information and recommendations from TJC. All recommendations from TJC will be considered, and implemented as appropriate. Other published information and internal aggregate information may also be considered in establishing proactive patient safety monitors. These will be monitored on an ongoing basis and reported to the Patient Safety Council, Medical Executive Committee and Governing Board at least quarterly.

8. **Proactive identification and management of potential risks to patient safety to prevent adverse occurrences rather than reacting to them.**
   Implementation:
   Along with proactive risk assessment activities identified above, each department/service, led by the director/manager, will review sentinel event alert information to conduct proactive risk assessments to determine if it is applicable to their department/service. If applicable, the department/service will be responsible for implementing risk reduction strategies to prevent the occurrences from happening.

9. **At least annually, select at a minimum of one high-risk process for proactive risk assessment, based in part on TJC Sentinel Event information and/or UHS Risk Alerts.**
   Implementation:
   At least annually, the Patient Safety Council will select a minimum of one high-risk process for proactive risk assessment based on UHS Risk Alert, TJC sentinel event information, other published information, and internal information.

10. **Assess intended and actual implementation of process to identify steps in the process where there is, or may be, undesirable variation (what engineers call the potential "failure modes"). Ongoing education of "FMEA" concepts will be taught to all departments to ensure working teams have the knowledge base to be effective.**
    <u>Implementation</u>:
    For each selected proactive patient safety monitor, a flow chart will be completed demonstrating the intended process and the actual process. Potential "failure mode" points will be identified and proactive actions taken to reduce these risks.

11. **For each identified "failure mode", identify possible effects on patients (what engineers call "effect") and how serious the possible effect on the patient could be (what engineers call "criticality" of the effect).**
    <u>Implementation</u>:
    When a "failure mode" is identified in the process, it will be assessed on the possible effects on the patient, rating the effect to no, low, moderate, or high risk for possible adverse effect.

12. **For the most critical effects, conduct root cause analysis to determine why the variation ("failure mode") leading to the effect may occur.**
    <u>Implementation</u>:
    For those "failure modes" identified as high risk for possible adverse patient effect, a root cause analysis will be conducted to determine why the variation may occur.

13. **Redesign the process and/or the underlying systems to minimize the risk of that "failure mode" or to protect patients from effects of that "failure mode".**
    <u>Implementation</u>:
    When the root cause analysis is conducted for "failure modes" which may cause possible adverse patient effects, the process will be redesigned to minimize the risk and protect patients from harm.

14. **Test and implement the redesigned process.**
    <u>Implementation</u>:
    Once the process is redesigned, the staff will be educated on the process. It will be implemented and tested for a trial period.

15. **Identify and implement measures of the effectiveness of the redesigned process.**
    <u>Implementation</u>:
    Once the process is redesigned, the staff will be educated and monitors will be put in place to ensure the redesigned process is effective.

Title: Patient Safety Plan	Policy No. PI-101
	Effective Date: 1/03
Reviewed: 12/07, 3/15, 2/16	Revised: 10/04,10/05, 12/06, 2/09, 10/09, 2/11, 4/13, 2/14	Page: 7 of 8

16. **Annual report to the governing body on occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.**
    Implementation:
    Once the redesigned process is monitored over time, and improvement is maintained, indicators may be implemented into other ongoing PI monitors to ensure the improvement is sustained. Periodic monitoring may also be utilized to ensure the improvement is sustained.

17. **This plan will be reviewed and updated annually in order to reflect the most current practices in the industry and the directives of corporate UHS.**
    Note: Also see Sentinel Event Policy and Serious Incident and Root Cause Analysis Policy

APPROVAL – SIGNATURE PAGE

_____ _____
Dir. Risk Management   Date

_____ _____
Chief Nursing Officer   Date

_____ _____
CEO   Date

_____ _____
Chair – Medical Executive Committee   Date

_____ _____
Chair – Governing Board   Date

PGH PERSHING GENERAL HOSPITAL & Nursing Home	Policy Name: **Patient Safety Plan**	
	Department(s) Affected **Facility Wide**	Policy #:
	Effective Date: 1/28/2016	Revision #:
Approved by: CEO, Risk Manager, Safety Officer, Board of Director		Date Approved:
This P&P complies with the following regulation(s): NRS 4393865, NRS 539.830, NRS 439.877		

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 improvement;

    e. Minimization of individual blame or retribution for involvement in a medical/health care error;

    f. Organizational learning about medical/health care errors with implemented plans of corrections;

    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 occurrence; 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. Patient care and 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. Patient6 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 activity efforts. Types of patient safety or medical/health care errors included the date analyses are:

1. 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.

2. 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.

3. Any Medication Error

4. Any Adverse Drug Reaction

5. Any Transfusion Reaction

6. Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

7. Sentinel Event – is defined as an unexpected occurrence, involving facility acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function (NRS 439.830). It is called a sentinel event because it signals the need for immediate investigation and response.

    The Mandatory reportable sentinel events include events that have resulted in an unanticipated death or major permanent loss of function.

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. These will be an emphasis on important facility and patient care functions of:

1. Patient Rights including freedom from abuse/neglect;

2. Assessment of Patient;

3. Care of Patients to include special considerations;

4. Patient/Family and Lay caregiver Education

5. Continuum of Care

   6. Management of Information

   7. Management of Human Resources

   8. Management of the Environment of Care

   9. 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 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 pat6ient safety activities as appropriate. Issues of great importance will also be reported to CEO/Administration as they occur.

   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:

      1. Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identification of the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be;

      2. For the most critical effects, a root cause analysis to determine why the undesirable variation leading to the effect may occur;

      3. Process and/or underlying systems will be redesigned to minimize the risk of theat undesirable variation or to protect patients from the effects of that undesirable variation;

      4. Redesigned process that are tested and implemented;

      5. Identify and implement measures of the effectiveness of the redesigned process;

      6. A strategy for maintaining the effectiveness of the redesigned process over time and it's implementation.

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:

1.   Perform necessary healthcare interventions to protect and support the patient's clinical condition.

2.   As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others – example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.

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

g.   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.

h.   Report the medical/health care error to the staff member's immediate supervisor.

i.   Submit the occurrence report to the Director of Risk/Quality Management per organizational policy.

j.   Any individual in any departme4nt 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.

k.   Staff response to medical/health care errors is dependent upon the type of error identifies;

1.   No Harm Errors – (including "no harm" medication errors) – staff will _document appropriately_ in the medical record according to organizational policy, document the circumstance 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.

2.   Mild-Moderate Adverse Outcome Errors (including medication errors) – Staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document fats appropriately in the medical record and on an occurrence report – submitting the report to the Director of Risk/Quality Management per organizational policy.

a. Mediation Errors – the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Pharmacy Services Department of the event and the immediate department director.

3. 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 medial 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.

4. 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. Blood will be saved for evaluation.

5. Hazardous Condition/Patient Safety Issue – as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue, and then identify 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.

6. Sentinel Events – staff will perform any necessary clinical interventions to support and protect the patient and notify the patient/residents next of kin, guardian etc. and the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the organizational Sentinel Event Policy and Procedure.

7. 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 policies (such as the Sentinel Event Policy) and/or the Safety Committee will determine the organizational response to medical/health care errors and occurrence. All sentinel events and near miss occurrence will have a root cause analysis conducted and report to CEO, CNO and Department Manager. The determination of the Safety Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine.

1. Further remedial action activities necessary for identified occurrences

2. Proactive occurrence reduction activates

3. 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.

1. Sentinel Events – staff members involved in a sentinel event occurrence will receive support from the Safety Committee regarding the staff membe3r'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 Departmen6, Human Resources Department and/or his or her department supervisor.

j. 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.

k. Staff will educate patients and lay caregivers 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.

l. 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 care givers and all other involved in the utilization of data.

m. 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.

n. 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.

o. Patient safety reports from the Safety Committee will be submitted to the organizational Quality Improvement Committee, which exists as the oversight committee for all Safety Committee. A monthly data report and recordings of meeting minutes will be forwarded to the Quality Improvement Committee, with all information submitted held under the auspices of the Quality Improvement Committee.

p. 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.

The patient Safety Committee will be composed of (NRS439.875):

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

The patient Safety Committee will meet monthly.

RED ROCK BEHAVIORAL HEALTH HOSPITAL
POLICY AND PROCEDURE MANUAL

DEPARTMENT: Environment Of Care	SUBJECT: Safety Management Plan

POLICY AND PROCEDURE: 800.101	Page 1 of 19
FUNCTIONAL AREA: Safety Management Program	REFERENCES: N/A
EFFECTIVE DATE: 08/2005	APPROVED BY: Quality Council/ Governing Board 08/05, 04/11
REVIEWED/REVISED: 11/10, 2/11, 8/11, 12/15	

I. Policy:

Red Rock Behavioral Health Hospital (RRBHH) will have an active safety plan to outline operation processes designed to manage staff activities that will reduce health care errors, the risk of human injury, and provide a safe physical environment for patients, personnel and visitors.

DEFINITIONS:

"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: 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 Health Division Administrator by regulation pursuant to NRS 439.890, AB59

1. Error - an unintentional act either of omission or commission, or an act that does not achieve its intended outcome.
2. Sentinel Event - NRS 439.830 Defined: "Sentinel event" is 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. The sentinel event applies to events that meet the following criteria:
    - The event has resulted in an unanticipated death or major permanent loss of function[1] not related to the natural course of the patient's illness or underlying condition, (note: a distinction is made between an adverse outcome that is related to the natural course of the patient's illness or underlying condition [not a sentinel event] and a death or major permanent loss of function that is associated with the treatment, or lack of treatment, of that condition), or,
    - The event is one of the following (even if the outcome was not death or permanent loss of function):
        - Suicide of a patient in a setting where the patient receives around-the-clock care (e.g., hospital, residential treatment center, crisis stabilization center), an attempted suicide or

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- Infant abduction or discharge to the wrong family, or
- Rape, the determination of which is to be based on the hospital's definition consistent with applicable law and regulation. Defined as un-consented sexual intercourse involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the medical facility, one or more of the following must be present to determine applicability of the reporting requirement: any staff-witnessed sexual intercourse; sufficient clinical evidence obtained by the medical facility to support allegations of un-consented sexual intercourse; or admission by the perpetrator that sexual intercourse occurred. An attempted rape is also a reportable sentinel event.
- An allegation of rape shall be investigated and the root cause analysis initiated when the determination is made that a rape has occurred, or
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities, or
- Surgery on the wrong patient or wrong body part.

 A major permanent loss of function means sensory, motor, physiological, or intellectual impairment not present on admission requiring continued treatment or life-style change.

Root Cause Analysis (RCA): An evaluation process structured to attempt to determine underlying causes of the sentinel event and whether there is a reasonable potential for process improvement to reduce the likelihood of such events in the future. The following are characteristics of a root cause analysis:

- Focus primarily on systems and processes, not individual performance;
- Progression from special causes in clinical processes to common causes in organizational processes;
- The use of "Why?" repeatedly as each reason is determined; and
- Identification of changes, if any, that should be made in systems and processes, either through redesign or development of new systems or processes, that would reduce the risk of recurrence of that sentinel event.

Mandatory Reporting of Sentinel Events:
Except as otherwise provided in subsection 2:

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(a) A person who is employed by a medical facility (Red Rock Behavioral Health Hospital) shall, within 24 hours after becoming aware of a sentinel event that occurred at a medical facility, notify the patient safety officer of the facility of the sentinel event; The patient safety officer shall, within 13 days after receiving notification pursuant to paragraph (a), report the date, the time and a brief description of the sentinel event to the Health Division, complete Section I of the Nevada State Health Division sentinel event form; and the representative designated pursuant to NRS 439.855, if that person is different from the patient safety officer. If the patient safety officer of a medical facility personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at the medical facility, the patient safety officer shall, within 14 days after discovering or becoming aware of the sentinel event, report the date, time and brief description of the sentinel event to the Health Division and representative designated pursuant NRS 439.855, if that person is different from the patient safety officer. The administrator shall prescribe the manner in which reports of sentinel events must be made pursuant to this section.

An Amendment shall be completed and submitted to Nevada State Health Division when the facility finds it necessary to amend the original sentinel event report.

Section II of the Nevada State Health Division sentinel event form must be completed and submitted to the Nevada State Health Division within 45 days after the medical facility is notified of the sentinel event.

Annually prepare a summary of the reports on or before 3/1 of each year. The facility shall provide the summaries to the Health Division.

3.   Critical Event - Critical event applies to events that meet the following criteria: The event results in or has the potential to cause serious harm or death (even if the outcome was not serious harm or death):
- Suicide of any patient other than an inpatient or who has been discharged from the facility's inpatient, partial hospitalization, outpatient or other service program within 30 days prior to the suicide, or
- Attempted suicide of any patient (that does not result in a major loss of permanent function), or

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- Any actual or alleged inappropriate sexual contact between staff and current patients or individuals who are patients within two years from discharge, (to include inappropriate verbal or written communication and/or inappropriate physical contact), or
- Sexual contact between patients involving any touching of genitalia, or
- Patient elopement, or
- Staff/patient or patient/patient aggression resulting in injury to the patient, or
- Medication error resulting in injury to the patient, or
- Significant adverse drug reaction, including incidents where the correct drug and dosage were administered, yet the patient suffered a major reaction which may have precipitated a medical emergency, or
- Falls with significant injury.

Critical Event Analysis: An evaluative process structure to attempt to determine underlying causes of the critical event and whether there is a reasonable potential for process improvement to reduce the likelihood of such events in the future. The following are characteristics of a critical event analysis:
- Focus primarily on systems and processes, not individual performance;
- Progression from special causes in clinical processes to common causes in organizational processes;
- The use of "Why?" repeatedly as each reason is determined; and
- Identification of changes, if any, that should be made in systems and processes, either through redesign or development of new systems or processes, that would reduce the risk of recurrence of that critical event.

4. Near Miss - use to describe any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of a sentinel event but outside the scope of those sentinel events which are subject to review by the Joint Commission on Accreditation of Healthcare Organizations under its Sentinel Event Policy.

5. Hazardous Condition - any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increases the likelihood of serious adverse outcome.

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6.   Medication Variance – any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, or patient.   Such events may be related to professional practice, pharmaceutical products, procedures, & systems, including prescribing; order communication; product labeling; packaging and nomenclature; dispensing; distribution; administration; education; monitoring; and use.

7.   Adverse Drug Reactions (ADR):   any undesired, unintended, excessive or exaggerated effect of a drug administered to a patient within the facility due to either the drug itself or patient idiosyncrasy (excluding gross overdose and therapeutic failure).   These reactions may be expected or unexpected.

SAFETY PLAN PHILOSOPHY:

The focus of this plan is to identify and reduce risks to patient safety, improve health outcomes of patients, and employee safety.   The hospital environment is one, which values the highest standards of quality and ethics integrity.   Open communication and safety reporting is encouraged and a nonpunitive philosophy presides, focusing on systems and processes rather than individual blame.   Individuals involved in a risk event (staff, visitor, patient, family) will be offered an opportunity to process/express feelings in a safe and therapeutic environment.

All departments/personnel are responsible to contribute to data collection, resolution of problems and continued monitoring using the DMAIC PI model of safety issues.   An interdisciplinary process (formal and informal) is encouraged to enhance positive outcomes.   A competent work force is paramount in maintaining a safe practice; therefore every department will develop an employee competency program which is reviewed by Human Resources.

SCOPE:

The Safety Plan includes all buildings and facilities operated by RRBHH and apply to all employees, physicians, other independent practitioners, vendors, patients and visitors.   It also applies to all activities conducted by staff members off site while conducting activities required by their position at the Hospital.

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The scope of the Plan entails the following operational components: safety policies and procedures, safety checklist, safety education and training, hazard surveillance (including product recall), employee incident reports, security program, hazardous materials and waste Plan, emergency preparedness program, quality improvement program, risk Plan, life safety Plan, medical equipment Plan, utilities Plan and medical/health care errors/factors that contribute to unanticipated patient outcomes.

GOALS:

The Safety Plan functions to create a culture of safety by maintaining a safe environment for patients, personnel, and visitors through compliance with regulations, procedures, and standards set forth by OSHA, The Joint Commission, CMS, HIPAA, National Fire Code, the City of Las Vegas Fire Marshall's office, State of Nevada, and Standard Building Codes, as well any Professional Discipline Regulatory Agencies.

Short-term objectives of the Safety Plan will be identified annually by the Safety Committee Members. These will be based on annual evaluation results of the Safety Plan, Safety Checklist, Safety Policies and Procedures, and unresolved safety issues. Consideration will be given to any additional Patient Safety Checklists that may be appropriate for adoption for use at the medical facility.

Revisions to the Safety Checklist and safety Policies and Procedures will be adopted, as necessary to ensure they reflect the most current standards in patient safety protocols.

OBJECTIVES:

The objectives of the Plan are to:

- Establish and implement operational processes which guide, monitor and/or evaluate safety management practices.
- Identify the organizational components responsible for safety management functions at RRBHH and delineate the relationship among these components including lines of authority, responsibility and accountability.

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- Identify and resolve safety management issues that result in environmental hazards and unsafe practices with special attention to hazards related to the ages of the patients served.
- Evaluate results of actions taken by individual departments to meet safety recommendations.
- Provide reports of safety management activities to RRBHH Board of Trustees, Administration, and department heads, including the Director of Performance Improvement.
- Provide effective process for supervising all grounds and equipment.
- Provide processes for conducting risk assessments that evaluate the buildings, grounds, equipment, occupants, and other physical systems on patient and public safety.
- Provide processes for reporting and investigating all incidents or abnormal occurrences that involve the building, patients, staff, and visitors.
- Discuss and evaluate sentinel events to reduce the number and severity of sentinel events. Review and evaluate measures carried out by the facility to improve the safety of the patients. Report recommendations to the Quality Council.

RESPONSIBILITY AND AUTHORITY:

Governing Board: Red Rock Behavioral Health Hospital Board of Trustees has the responsibility, authority, and accountability for requiring, supporting the establishment and maintenance of an effective hospital-wide Safety Plan. The Board has authorized the Chief Executive Officer the responsibility to implement a Safety Plan, which is approved annually.

Chief Executive Officer: The Chief Executive Officer (CEO) has the responsibility to provide necessary staffing and equipment for the Safety Plan; and require hospital staff participation by all departments. The CEO has authorized the Safety Officer the responsibility for development, implementation, and monitoring of the Safety Plan. The CEO and Medical Director through the Medical Executive Committee authorize the Safety Officer to intervene whenever conditions exist that pose a threat of damage to equipment or building.

Quality Council: The Quality Council monitors the effectiveness of the Safety Plan and is authorized to designate resources and priority levels to the Safety Committee's recommendations. The Quality Council approves the annual Safety Plan.

Safety Committee: The Safety Committee is a standing committee designed to analyze identified safety management issues and to develop recommendations for resolving them.

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- The Safety Committee will meet at least one time per month, with an agenda and minutes completed for each meeting.
- The Committee will review the Patient Safety Checklists and will ensure items are monitored, effectiveness will be documented and discussed, and revisions will be made as necessary.
- The Chairman of the Safety Committee will be appointed by the Chief Executive Officer.
- The Committee will be composed of: the patient safety officer of the medical facility; at least 3 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. Additionally the committee must have at least one member of the medical executive or governing body of the medical facility.
  The Committee will adopt patient Safety Checklists and Policies and Procedures to improve the health outcomes of Red Rock Hospital.
- Review and revise the Safety Checklist, Safety Plan policies and procedures for accuracy, completeness, and proper implementation, and reflection of most current standards.
- The Patient Safety Checklists will include, without limitation:
  1. Reviews of documentation that treatment provided was properly ordered by the provider of health care.
  2. Ensures the overall environment and the patient rooms are safe and sanitary.
  3. Ensures a checklist is used when discharging a patient from the facility which includes, without limitation, verifying the patient received:
     a. Proper instructions concerning prescription medication
     b. Instructions concerning aftercare
     c. Other instructions concerning his/her care upon discharge
  4. Any other items needed to ensure safety of the patients at Red Rock Hospital
- Patient Safety Policies and Procedures will include, without limitation:
  1. A policy for appropriately identifying a patient before providing treatment. The policy must include the patient be identified with at least 2 personal identifiers, without limitation, the name and, date of birth of the patient.
  2. A policy regarding the nationally standard precautionary protocols to be observed by providers of health care including, without limitation, hand washing.

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3. A policy to ensure compliance with the patient safety checklists and patient safety policies adopted include, without limitation, active surveillance, reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

- Monitoring system user training programs and directing changes as appropriate.
- Monitoring safety systems and processes as it relates to the overall quality of the patient care environment.
- Developing and monitoring Performance Standards for the Safety Plan.
- The Committee will receive on a regular basis summary reports from the following areas:
  1) Patient and visitor safety variances
  2) Personnel injuries and occupational illness incidents
  3) Personnel and visitor security incidents and property damage
  4) Medical equipment and utility management disruptions
  5) Hazard surveillance, product recall, fire safety, and all safety and security investigations
  6) Fire drill and emergency preparedness evaluation data
  7) Life Safety (to include all aspects of fire devices, i.e., sprinkling system, fire extinguishing systems, etc.)
  8) Performance Improvement results of monitoring and evaluation activities related to hazards and safety practices
  9) Risk Management issues related to hazards and safety practices
  10) Infection Control activities related to hazards and safety practices
  11) Sentinel Event reports. Additionally the committee will evaluate the actions of the patient safety officer in connection to the Sentinel Events.

The EOC/IC/Safety will make recommendations to analyze identified safety management issues and to develop and approve recommendation for solving them and to monitor the effectiveness of the changes to see if correction/improvement occurs.

The EOC/IC/Safety will, at least annually, review of the Safety Plan, Safety Checklist and Safety Policies and Procedures. Consideration will be given to any additional Patient Safety Checklists that may be appropriate for adoption for use at the medical facility.

The EOC/IC/Safety will receive results of the annual evaluation of the Safety Plan and revise as necessary and forward the plan to Quality Council.

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The EOC/IC/Safety will conduct and document a summary of an annual review. The report will include information regarding the development, revisions and usage of the patient safety checklists and patient safety policies and procedures. On or before each July1 a summary of the report shall be submitted to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care.

Safety Officer: The Safety Officer has the responsibility to manage an ongoing hospital-wide process to collect and evaluate information about hazards and safety practices that is used to identify safety management issues to be addressed by the EOC/IC/Safety. The Safety Officer will:

- Report at least monthly to the EOC/IC/Safety on findings, recommendations, actions and monitoring conducted by the Safety Department. This includes but is not limited to hazard surveillance, product recall, fire safety, incident investigation.
- Participate in hazard surveillance, product recall and incident reporting on a regular basis.
- Participate in the development of departmental and organization-wide safety policies and procedures.
- Participate in Safety education orientation program for new employees and in continuing education for all employees.
- Be a member of the EOC/IC/Safety and Quality Council.
- Work with appropriate staff to implement EOC/IC/Safety recommendations and to monitor effectiveness of the changes.
- Prepare reports of safety management issues and summaries of EOC/IC/Safety activities for communication and distribution to Quality Council and the Board of Directors and designated hospital personnel.
- The Safety Officer will work with the EOC/IC/Safety, Quality Council and the PI Director to develop and monitor Performance Standards for the Safety Plan.
- Participate in Root Cause Analysis related to sentinel event reporting.

Performance Improvement (PI) Director: The PI Director is responsible for the planning, implementation, monitoring and evaluation of Performance Improvement clinical activities including safety and risk events as well as proactive safety improvements and risk reduction strategies. The PI Director serves as a resource for regulatory compliance and risk management

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consultation. The PI Director works collaboratively with the Safety Officer to establish a Safety Plan and monitor the effectiveness of the plan. (Refer to PI and Risk Management sections)

Department Heads: Department Heads are responsible for establishing departmental safety programs. Safety precautions applicable to the department will be written form either collectively or inclusive in the various job functions. Each department head is responsible for employee safety awareness/education; monitoring or compliance to safety related policies and procedures; corrections of safety deficiencies and proper reporting of safety incidents/hazardous.

Employees: Hospital employees are responsible for adhering to safety policies and procedures, reporting environmental hazards and safety incidents/variances, and making recommendations for the improvement of the Safety Plan and the overall Environment of Care.

SAFETY RISK/ERROR REDUCTION:

1. RRBHH recognizes that a patient has the right to a safe environment therefore the organization is committed to undertaking a proactive program to identify processes which may adversely affect patient safety or be associated with medical errors.
2. Effective reduction of errors and other factors that contribute to unintended adverse patient outcomes in our organization requires an environment in which patients, their families, and organizational staff and leaders can identify and manage actual and potential risks to patient safety. Our environment must encourage:
    a.   Recognition and acknowledgement of risks to patient safety.
    b.   Organizational focus on process and systems assessment and improvement related to patient risk and safety.
    c.   Initiation of actions to reduce these risks.
    d.   Internal reporting of what has been found and the actions taken.
    e.   Minimization of individual blame or retribution for involvement in a medical error.
3. RRBHH has delegated oversight of our patient safety and error reduction program to Quality Council.
4. Quality Council shall report to the Medical Executive Committee and the Medical Executive Committee will report on a regular basis to the Board of Trustees. Quality Council will on a regular basis aggregate and assess all organizational data related to

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adverse events; incident reports; risk management; environmental safety clinical outcome measurements; risk concerns and provide a report to the Medical Executive Committee and Board of Trustees.

5. At least annually, Quality Council will select at least two (2) high-risk processes for proactive risk assessment and risk reduction. High-risk process selection shall be based on information published periodically by the Joint Commission or other nationally recognized sources of information on patient safety and medical errors. The processes selected for proactive risk assessment and risk reduction should include those processes known to be associated with sentinel events, significant patient risk or medical errors in other organizations.

6. Quality Council shall oversee the development of a program to reduce medication related errors. The medication error reduction program shall incorporate the principles of medication error reduction which have been identified by the Joint Commission and by other nationally recognized sources of patient safety and error reduction strategies. RRBHH recognizes medication errors as medication variances.

7. RRBHH understands that inconsistency in the performance of existing organizational processes frequently leads to unanticipated and/or undesirable results. In order to minimize risk to patient safety due to undesirable process variations, Quality Council will require ongoing monitoring to ensure that processes identified as variance prone or high risk regarding patient safety are being performed. Each year the performance of critical steps in at least 1 process shall be subject to ongoing measurement and analysis to determine the degree of variation from intended performance. If undesirable process variation is identified Quality Council shall refer their assessment findings to the appropriate committee or team for prioritization of a performance improvement project.

8. Specific processes should be considered for performance improvement prioritization. Identification of risk can occur through:
   • Self report
   • Performance Improvement reporting and trending
   • Performance Improvement Team activities
   • Proactive measurement of high risk, problem prone processes
   • Failure Mode Evaluation (including near misses)

9. Quality Council will assure that knowledge-based information, including journal literature, clinical practice standards or guidelines, reference information and research data, is utilized in process design and process redesign. Quality Council shall assure that

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knowledge based information is used and the development of at least one (1) clinical practice guideline (Best Practice) on an annual basis.

FUNCTIONS TO BE INCLUDED IN PATIENT SAFETY AND ERROR REDUCTION COMMITTEE DUTIES

Performance Improvement

1. Establish measurable objectives for improving patient safety and reducing medical errors. Measurable objectives shall be based on the elements of patient safety and error reduction which are described in this Plan.
2. Review and evaluate all sentinel/critical events including the development of a thorough and credible root cause analysis or critical event analysis, appropriate plan of correction, and follow up plan. Discuss and evaluate sentinel events to reduce the number and severity of sentinel events. Review and evaluate measures carried out by the facility to improve the safety of the patients. Report recommendations to the Quality Council.
3. Review and disseminate available information about sentinel events known to occur in other health care organizations that provide services similar to RRBHH. This includes review of all TJC sentinel event alerts through Quality Council.
4. Assuring that prioritization is given to those events and processes most closely associated with patient safety when developing the organizational measurement program and in selecting specific improvement activities.
5. Assuring that the data which the organization considers for collection to monitor performance shall include the following:

   a. Patient, family and staff opinions, needs, perceptions of risks to patients, and suggestions for improving patient safety.
   b. Staff willingness to report medical/health care errors/variances.
   c. Data about the needs, expectations, and satisfaction of individuals and organizations served. RRBHH will ask these groups specifically how the organization can improve patient safety.
6. Aggregating organizational information related to patient safety and medical errors to identify trends or patterns in process or outcome, which may lead to untoward patient events.

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7.   Assuring that when organizational processes are designed or redesigned, information from other organizations related to potential risks to patient safety, including occurrence of sentinel/critical events, is reviewed and risk reduction strategies are implemented in the designed or redesigned process.

Information Management

1.   Quality Council shall work with appropriate organizational staff in developing the hospital information management needs assessment. The needs assessment shall include information regarding barriers to effective communication among caregivers. Specific attention will be directed to the processes for assuring accessibility of accurate, timely and complete verbal and written communication among caregivers and all others involved in the utilization of data (including external sources).

2.   Working collaboratively with staff to assure the medical record is audited on a regular basis to verify that all information necessary to assure patient safety and reduce medical errors is contained in the medical record in a timely manner.

3.   Development of program to assure that knowledge-based information is available to clinicians to support clinical management and decision making in a timely manner, including internet access, journal subscriptions, corporate and community networking and collaborative efforts.

Environment of Care (EOC)

1.   Aggregate and assess organizational data related to environmental issues associated with patient safety and risk.   Each of the three (3) EOC elements has an individual management plan. These plans are reviewed annually by the EOC/IC/Safety, Quality Council, Medical Executive Committee and Board of Trustees.   Additionally, departments develop specific safety policies to promote safety practices and reduction of risk opportunities.

Risk Management

1.   Provide oversight of all organizational risk management activities.

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2. Develop an organizational-wide approach to the reporting and evaluation of potential medical errors.

3. Develop procedures for immediate response to medical errors including care of the affected patient, containment of risk to others and preservation of factual information for subsequent analysis.

4. Develop systems for internal and external reporting of information relating to medical errors.

5. Aggregation and trending of all risk management information to identify those events or processes which are associated with patient safety and/or medical errors.

6. Develop procedures to be followed related to the notification of patients and when appropriate their families about unanticipated error outcomes or medical errors.

Human Resources

1. Ensure that each staff member participates in ongoing in-service, education, and training to increase his or her knowledge of job-related aspects of patient safety.

2. Assure that ongoing in-service and other education and training programs emphasize specific job-related aspects of patient safety. As appropriate, this training incorporates methods of team training to foster the interdisciplinary collaborative approach to the delivery of patient care and reinforces the need and ways to report medical care errors.

3. Define a mechanism for the support of staff that is involved in medical errors or sentinel/critical events.

Patient and Family Education

1. Work with staff in the development of programs to enhance involvement by the patient and patient's family as appropriate to his or her condition as a partner in the health care process.

2. Oversee the development of programs to educate the patient and families about their role in helping to facilitate the safe delivery of health care.

3. Oversee the development of programs to educate patients and families regarding their responsibility for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.

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4.   Work with staff to assure that patient education programs are implemented related to safe and effective use of medications.

Safety Risk Continuum of Care

The patient and staff safety standards meet regulatory requirements throughout the continuum of care at RRBHH. Department Heads review standards to ensure compliance for off-campus sites and when providing community services. Safety risk identification and follow through remains intact regardless of level of care or site location.

Safety Risk Event Documentation/Notification

It is the policy of RRBHH that patients and, when appropriate, their families are informed about outcomes of care including unanticipated outcomes. It is the obligation of the responsible licensed independent practitioner or his or her designee to clearly explain the outcome of any treatment or procedure to the patient and, when appropriate, to the patient's family whenever those outcomes differ significantly from anticipated outcomes. Quality Council shall institute monitoring programs to assure that information regarding unanticipated outcomes is shared with patients and, when appropriate, their families in a timely manner.

Risk events are to be accurately documented in the medical record. Patient and non-patient related events are to be documented using appropriate internal reporting tools. Routing of this documentation is diagramed below to ensure preservation of information to appropriate notification of key caregivers (i.e., attending physician, medical physician, therapist, etc.). To encourage accurate reporting the hospital supports the Supervisor's authority to impact changes to avoid similar risk events. This includes: time limited milieu modifications, import additional staff or modify staffing pattern, notification of vendors or other department personnel to make necessary changes.

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Observe Risk Event → Immediate Supervisor → Dept Head → PI/RM &/or Safety Officer → and/or → Patient Safety Committee → MEC → Board of Trustees

PI/RM &/or Safety Officer → Corp RM

PI/RM &/or Safety Officer → Quality Council

Patient Safety Committee → Quality Council

Quality Council → MEC

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Addendum A

The patients and family if applicable are to be informed of unanticipated outcomes by the attending physician/designee unless such information is deemed detrimental to the safety of the individual. Such a sanction requires a second opinion by a psychiatrist and administrative approval.

Patient/family notification is documented in the Progress Notes, signed by the attending physician and witness by an additional care giver attending the meeting. Should information be deemed detrimental, Risk Management is contacted and provides opportunity for the second opinion to be documented and reviewed by Administration. The approval or other direction is noted and followed accordingly.

Addendum B

Immediate response to medical errors:

- Follow communication algorithm for notification
- Provide care per policy and physician orders
- Supervisor to determine risk containment measure including
  - Staffing/personnel changes
  - Equipment replacement
  - Relocation of patients
  - Modification of processes/program
- Preservation of factual information
  - Event is to be documented immediately in Progress Notes and via Risk Management tools.
  - Equipment including videotapes, medical devices, instruments, photos is to be locked in Risk Management.
  - Event analysis is to occur within 24 hours of notification.

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- Events necessitating reporting to outside agencies (i.e., CPS, Adult Protective Services, Police, and insurance carriers) will be handled promptly and with full commitment to the governing regulations by the CEO or designee.

Renown Health
PATIENT SAFETY PLAN
2015 - 2016

Introduction

The Patient Safety Program supports and promotes the culture of safety, and the mission, vision and values of Renown Health through the continuous improvement of patient, visitor, and employee safety. This Plan is implemented through the integration and coordination of the patient safety activities of the medical staff, clinical departments and support service departments at Renown Health. Each employee and staff member plays a critical role in ensuring patient, visitor and employee safety. The organization wide patient safety program is designed to promote patient, visitor and staff safety by reduction of medical errors and hazardous conditions by utilizing a systematic, coordinated and continuous approach. This approach centers on the establishment of mechanisms that support effective responses to actual occurrences and hazardous conditions; ongoing proactive reductions in medical/health care errors; and integration of patient-safety priorities in the design and redesign of all relevant organizational processes, functions and services.

The Renown Health integrated patient safety program is implemented through the Renown Health Patient Safety Committee (PSC or "Committee"). This program provides oversight and ensures alignment of patient safety activities and opportunities for all individuals who work in the organization. It also serves to educate and encourage staff participation in patient safety initiatives.

Purpose

The purpose of the Patient Safety Plan (Plan) is to reduce mortality and morbidity, improve patient care by the identification, analysis and reduction of risks, which could cause or have caused preventable patient injury or impairment of patient safety.

Priorities

The priorities of the 2015-2016 Plan are to:

1. Ensure compliance with the Joint Commission National Patient Safety Goals

2. Measurably improve the Renown Health patient safety culture by:

    a. Conducting a Culture of Patient Safety survey and develop action plans based on results.

    b. Standardize key information within safe hand offs, providing an opportunity to ask and respond to questions

    c. Utilizing Environment of Care rounding, tracer activity and continuous readiness activities to provide compliance and process improvement opportunities

3. Adopt annually, patient safety checklists utilized throughout Renown Health

4. Ensure there is an ongoing infection control program.

5. Regularly brief the Board and senior administrative leaders regarding the results of:

    a. Root Cause Analysis, including the corrective action plans complete with implementation schedules and metrics for determining success. There will also be briefings that report the results of corrective action plans and any further activities required if the success targets were not achieved.

    b. Safety culture measurements and performance improvement initiatives implemented

    c. Progress towards patient safety risk and hazard reduction

6. Communicate patient safety initiatives to patients, family members and visitors.

7. Encouraging patient and advocate participation in patient care plans, bedside shift report and leadership rounding. Patients and/or family advocates will continue to participate by providing input to the leadership regarding the management of safety and quality issues within the system.

8. Identify and address processes that have a high risk of causing patient harm, using internal and external data

    a. Select at least one high risk process for proactive risk assessment (FMEA)

    b. Continue analysis of fall and fall with harm rates via a fall prevention team/task force

     c. Participate in the collaborative efforts to reduce inpatient readmission rates to reduce readmissions and increase patient and family satisfaction with transitions in coordination of care

9. Review the analysis of aggregate data from various patient safety activities including but not limited to the Patient Safety Indicator web based tool including the CMS Hospital Acquired Conditions

10. Enhance system-wide patient safety curriculum

11. Ensure the adoption of patient safety policies within Renown Health

12. Influence policy and standards development, at the state and national level, regarding patient safety through participation in NVHA as well as participating and presenting at state and national meetings

Organization, Authority and Responsibility

The authority of the Patient Safety Plan rests with the Governing Board. The Renown Health Board has delegated the authority to implement and maintain activities described in this plan to the Patient Safety Committee. The Patient Safety Program is a combination of Renown Health's Quality Management and each Renown Health entity's efforts. It is concerned primarily with those aspects of risk, which have an impact upon patient care issues. The PSC coordinates risk management efforts with the Environment of Care and Safety Committee functions to assure membership overlap and will provide appropriate information to that Committee in a manner consistent with the protection of confidentiality of patient and patient safety information. Environment of Care and other committees/work groups may bring patient safety concerns to the Patient Safety Committee.

The Patient Safety Committee is designated by the Governing Board as a committee formed to improve patient outcomes and reduce morbidity and mortality within the Renown Health System. The records, data and knowledge presented to and collected by this committee shall be used for those purposes, consistent with the purposes set forth in the Nevada Revised Statutes. As such, the records, data and knowledge collected by this committee are intended to be confidential, privileged and not public records and shall not be available for court subpoena per the Nevada NRS.

The Chief Executive Officer and Patient Safety Committee shall delegate authority to the Patient Safety Officer[1], to take the immediate and appropriate action in the event of an emergency situation where there is a clear and present threat to life, a threat of personal injury or a threat of damage to property.

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Duties

Patient Safety Committee

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The committee provides a multidisciplinary forum for the collection and analysis of patient safety information and the dissemination of material on identified risk for the purposes of improving patient care and reducing morbidity and mortality within Renown Health. It shall review reports on occurrences typically ranging from "no harm" frequently occurring "near misses" to sentinel events with serious adverse outcomes, claims and identified risks, which are gathered in accordance with this plan. It may identify those individuals or groups best situated to perform a root cause analysis and develop and implement an action plan for these identified gaps in patient safety. The Committee shall review, analyze and disseminate the information it receives, as appropriate, to the Executive Committee, chairmen of clinical departments and appropriate administrative personnel. It shall provide recommendations concerning identified risks and where appropriate shall request and approve plans for corrective action and evaluate the implementation of corrective actions taken.[2]

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[1] **NRS 439.870   Patient safety officer: Designation; duties.**

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

2.   The person who is designated as the patient safety officer of a medical facility shall:

(a) Serve on the patient safety committee.

(b) Supervise the reporting of all sentinel events alleged to have occurred at the medical facility, including, without limitation, performing the duties required pursuant to NRS 439.835.

(c) Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the medical facility.

(d) Report to the patient safety committee regarding any action taken in accordance with paragraph (c).

(Added to NRS by 2002 Special Session, 15)

[2] **NRS 439.875   Patient safety committee: Establishment; composition; meetings; duties; proceedings and records are privileged.**

1.   A medical facility shall establish a patient safety committee.

2.   Except as otherwise provided in subsection 3:

(a) A patient safety committee established pursuant to subsection 1 must be composed of:

(1) The infection control officer of the medical facility.

(2) The patient safety officer of the medical facility, if he or she is not designated as the infection control officer of the medical facility.

(3) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility.

(4) One member of the executive or governing body of the medical facility.

(b) A patient safety committee shall meet at least once each month.

3.   The Administrator shall adopt regulations prescribing the composition and frequency of meetings of patient safety committees at medical facilities having fewer than 25 employees and contractors.

The Director of Risk Management will lead the committee as the Patient Safety Officer. The Patient Safety Officer is responsible for managing all aspects of the safety plan. On behalf of the committee, the Patient Safety Officer or designee shall provide reports at least once each calendar quarter to the executive or governing body of the organization regarding its activities. This report shall include:

- The number of sentinel events that occurred during the previous calendar quarter

- The number and severity of infections that occurred during the previous calendar quarter

- Any recommendations to reduce the number and severity of sentinel events and infections that occur.

In addition, the Patient Safety Officer advises these groups regarding clinical issues that may necessitate changes to policies and procedures, orientation, on-going education, or resource allocation. The Patient Safety Officer is authorized by the committee to conduct investigations, participate as advisor in medical staff and administrative committees and has the responsibility for gathering information on risks to patient safety.

Medical Staff

Each member of the Medical Staff shall participate in the system-wide incident reporting system, and in the preparation and implementation of corrective action activities in the

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4.   A patient safety committee shall:

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(b) Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.

(c) Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.

(d) Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections at the medical facility.

(e) Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur at the medical facility.

(f) At least once each calendar quarter, report to the executive or governing body of the medical facility regarding:

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

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

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(g) Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

5.   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.

(Added to NRS by 2002 Special Session, 15; A 2011, 679, 1584)

event of identified risk as appropriate. Each clinical department shall implement the requirements of the plan, in accordance with the Joint Commission Standards established criteria for patient care and safety, by developing appropriate policies and procedures, identifying cases of potential risk areas and correcting identified safety concerns. In conjunction with its participation in departmental and system-wide quality improvement programs, each clinical department shall coordinate and incorporate patient safety indicators into its Medical Staff monitoring and evaluation systems for the purpose of monitoring and evaluating high-risk activities.

Each Renown Health department, which provides or affects patient care, reports identified patient safety risks to the Risk Management Department and correct identified safety concerns. Each department shall assure the participation of its members in the system-wide incident reporting system and in the preparation and implementation of corrective action plans. Department leadership is responsible for orientation of new staff members to the department and, as appropriate, to job and task-specific safety procedures. When necessary, the Chairpersons of the Patient Safety Committee and of the Environment of Care Committee will provide department heads with assistance in developing safety programs or policies.

Staff Members

Individual Renown Health staff are responsible for learning and following jobs and task-specific procedures for safe operations. Staff will participate in the system-wide incident reporting system.

Composition of the Patient Safety Committee

Membership is by appointment of the Chairperson(s) and includes representatives from each Renown Health Division. The Executive Vice President and Chief Medical and Academic Officer serves as an ex officio member of the Patient Safety Committee. The Patient Safety Committee meets monthly. Additional meetings may be scheduled at the call of the Committee Chair. Membership of the Patient Safety Committee will include, but is not limited to:

Vice President of Nursing for Renown Health

Vice President of Quality for Renown Health

Director of Risk Management for Renown Health

Director of Infection Control for Renown Health

Director of Accreditation & Regulatory Compliance for Renown Health

Director of Pharmacy for Renown Health

Director of Service Excellence for Renown Health

Patient Safety Officer

Infection Control Officer

Representation for each Division of Renown Health including as appropriate:

- Chief Medical Officer/Medical Provider
- Chief Nursing Officer/Nursing Provider
- Director of Quality or Quality Department Designee

Investigation, Analysis and Reduction of Risks

A broad range of data will be reported to and reviewed by the Patient Safety Committee. The results of investigations and analytical reviews may, in turn, be forwarded by the Committee to the appropriate entities for further, in-depth evaluation, review and response. Responses shall include any corrective action taken or plan for corrective action. The Patient Safety Committee will serve as a clearinghouse for these data and information which effect patient safety. The Committee will promote the application of evidence-based methods and will promote the use of shared metrics in the evaluation of related patient safety activities. In accordance with the incident reporting policy, all staff shall notify the Department of Risk Management of events typically ranging from "no harm" to sentinel events. Any incident, process or condition or event may be subject to investigation through Root Cause Analysis. Intensive assessment is initiated when undesirable patterns or trends are identified or a serious or sentinel event occurs (RENOWN.CID.150.00). No Medical staff member or employee will be subject to disciplinary action for reporting an occurrence. The mechanism for support of staff involved in a sentinel/adverse event are outlined in Patient Safety Event and Good Catch Reporting Policy RENOWN.CID.100.05.

Toward its goals of improving patient safety and reducing morbidity and mortality, the committee will coordinate with Risk Management to obtain information relating to patient safety from incident reports, patient complaints, patient claims. Proactive assessment of at least one high-risk process is conducted annually based on information from internal and external sources. Proactive assessment will be conducted utilizing FMEA or another acceptable process improvement methodology.

Patient Safety Educational and Research Activities

The orientation process emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing in-service and other education and training programs emphasize specific job-related aspects of patient safety. As appropriate, this training incorporates methods of team training to foster an interdisciplinary, collaborative approach to the delivery of patient care, and reinforces the need and way(s) to report medical/health care errors. The Patient Safety Committee shall plan and conduct educational activities in coordination with other educational efforts undertaken. In addition, the Patient Safety Committee will communicate issues of importance to clinical areas on a regular basis or when an issue is identified.

The safety of the health care delivery system is enhanced by the involvement of the patient, as appropriate to his/her condition, as a partner in the health care process. The comment card and patient satisfaction survey encourage the patient's participation and suggestions for changes in the system. Specific attention is directed at educating patients and families about their role in helping to facilitate the safe delivery of care.

Renown Health
PATIENT SAFETY PLAN
2015 - 2016

Introduction

The Patient Safety Program supports and promotes the culture of safety, and the mission, vision and values of Renown Health through the continuous improvement of patient, visitor, and employee safety. This Plan is implemented through the integration and coordination of the patient safety activities of the medical staff, clinical departments and support service departments at Renown Health. Each employee and staff member plays a critical role in ensuring patient, visitor and employee safety. The organization wide patient safety program is designed to promote patient, visitor and staff safety by reduction of medical errors and hazardous conditions by utilizing a systematic, coordinated and continuous approach. This approach centers on the establishment of mechanisms that support effective responses to actual occurrences and hazardous conditions; ongoing proactive reductions in medical/health care errors; and integration of patient-safety priorities in the design and redesign of all relevant organizational processes, functions and services.

The Renown Health integrated patient safety program is implemented through the Renown Health Patient Safety Committee (PSC or "Committee"). This program provides oversight and ensures alignment of patient safety activities and opportunities for all individuals who work in the organization. It also serves to educate and encourage staff participation in patient safety initiatives.

Purpose

The purpose of the Patient Safety Plan (Plan) is to reduce mortality and morbidity, improve patient care by the identification, analysis and reduction of risks, which could cause or have caused preventable patient injury or impairment of patient safety.

Priorities

The priorities of the 2015-2016 Plan are to:
1. Ensure compliance with the Joint Commission National Patient Safety Goals
2. Measurably improve the Renown Health patient safety culture by:
    a. Conducting a Culture of Patient Safety survey and develop action plans based on results.
    b. Standardize key information within safe hand offs, providing an opportunity to ask and respond to questions
    c. Utilizing Environment of Care rounding, tracer activity and continuous readiness activities to provide compliance and process improvement opportunities
3. Adopt annually, patient safety checklists utilized throughout Renown Health
4. Ensure there is an ongoing infection control program.
5. Regularly brief the Board and senior administrative leaders regarding the results of:
    a. Root Cause Analysis, including the corrective action plans complete with implementation schedules and metrics for determining success. There will also be briefings that report the results of corrective action plans and any further activities required if the success targets were not achieved.
    b. Safety culture measurements and performance improvement initiatives implemented
    c. Progress towards patient safety risk and hazard reduction
6. Communicate patient safety initiatives to patients, family members and visitors.
7. Encouraging patient and advocate participation in patient care plans, bedside shift report and leadership rounding. Patients and/or family advocates will continue to participate by providing input to the leadership regarding the management of safety and quality issues within the system.
8. Identify and address processes that have a high risk of causing patient harm, using internal and external data
    a. Select at least one high risk process for proactive risk assessment (FMEA)
    b. Continue analysis of fall and fall with harm rates via a fall prevention team/task force

c. Participate in the collaborative efforts to reduce inpatient readmission rates to reduce readmissions and increase patient and family satisfaction with transitions in coordination of care

9. Review the analysis of aggregate data from various patient safety activities including but not limited to the Patient Safety Indicator web based tool including the CMS Hospital Acquired Conditions

10. Enhance system-wide patient safety curriculum

11. Ensure the adoption of patient safety policies within Renown Health

12. Influence policy and standards development, at the state and national level, regarding patient safety through participation in NVHA as well as participating and presenting at state and national meetings

Organization, Authority and Responsibility

The authority of the Patient Safety Plan rests with the Governing Board. The Renown Health Board has delegated the authority to implement and maintain activities described in this plan to the Patient Safety Committee. The Patient Safety Program is a combination of Renown Health's Quality Management and each Renown Health entity's efforts. It is concerned primarily with those aspects of risk, which have an impact upon patient care issues. The PSC coordinates risk management efforts with the Environment of Care and Safety Committee functions to assure membership overlap and will provide appropriate information to that Committee in a manner consistent with the protection of confidentiality of patient and patient safety information. Environment of Care and other committees/work groups may bring patient safety concerns to the Patient Safety Committee.

The Patient Safety Committee is designated by the Governing Board as a committee formed to improve patient outcomes and reduce morbidity and mortality within the Renown Health System. The records, data and knowledge presented to and collected by this committee shall be used for those purposes, consistent with the purposes set forth in the Nevada Revised Statutes. As such, the records, data and knowledge collected by this committee are intended to be confidential, privileged and not public records and shall not be available for court subpoena per the Nevada NRS.

The Chief Executive Officer and Patient Safety Committee shall delegate authority to the Patient Safety Officer[1], to take the immediate and appropriate action in the event of an emergency situation where there is a clear and present threat to life, a threat of personal injury or a threat of damage to property.

Duties
Patient Safety Committee

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event of identified risk as appropriate. Each clinical department shall implement the requirements of the plan, in accordance with the Joint Commission

Standards established criteria for patient care and safety, by developing appropriate policies and procedures, identifying cases of potential risk areas and correcting identified safety concerns. In conjunction with its participation in departmental and system-wide quality improvement programs, each clinical department shall coordinate and incorporate patient safety indicators into its Medical Staff monitoring and evaluation systems for the purpose of monitoring and evaluating high-risk activities.

Each Renown Health department, which provides or affects patient care, reports identified patient safety risks to the Risk Management Department and correct identified safety concerns. Each department shall assure the participation of its members in the system-wide incident reporting system and in the preparation and implementation of corrective action plans. Department leadership is responsible for orientation of new staff members to the department and, as appropriate, to job and task-specific safety procedures. When necessary, the Chairpersons of the Patient Safety Committee and of the Environment of Care Committee will provide department heads with assistance in developing safety programs or policies.

Staff Members

Individual Renown Health staff are responsible for learning and following jobs and task-specific procedures for safe operations. Staff will participate in the system-wide incident reporting system.

Composition of the Patient Safety Committee

Membership is by appointment of the Chairperson(s) and includes representatives from each Renown Health Division. The Executive Vice President and Chief Medical and Academic Officer serves as an ex officio member of the Patient Safety Committee. The Patient Safety Committee meets monthly. Additional meetings may be scheduled at the call of the Committee Chair. Membership of the Patient Safety Committee will include, but is not limited to:

Vice President of Nursing for Renown Health

Vice President of Quality for Renown Health

Director of Risk Management for Renown Health

Director of Infection Control for Renown Health

Director of Accreditation & Regulatory Compliance for Renown Health

Director of Pharmacy for Renown Health

Director of Service Excellence for Renown Health

Patient Safety Officer

Infection Control Officer

Representation for each Division of Renown Health including as appropriate:

- Chief Medical Officer/Medical Provider
- Chief Nursing Officer/Nursing Provider
- Director of Quality or Quality Department Designee

Investigation, Analysis and Reduction of Risks

A broad range of data will be reported to and reviewed by the Patient Safety Committee. The results of investigations and analytical reviews may, in turn, be forwarded by the Committee to the appropriate entities for further, in-depth evaluation, review and response. Responses shall include any corrective action taken or plan for corrective action. The Patient Safety Committee will serve as a clearinghouse for these data and information which effect patient safety. The Committee will promote the application of evidence-based methods and will promote the use of shared metrics in the evaluation of related patient safety activities. In accordance with the incident reporting policy, all staff shall notify the Department of Risk Management of events typically ranging from "no harm" to sentinel events. Any incident, process or condition or event may be subject to investigation through Root Cause Analysis. Intensive assessment is initiated when undesirable patterns or trends are identified or a serious or sentinel event occurs (RENOWN.CID.150.00). No Medical staff member or employee will be subject to disciplinary action for reporting an occurrence. The mechanism for support of staff involved in a sentinel/adverse event are outlined in Patient Safety Event and Good Catch Reporting Policy RENOWN.CID.100.05.

Toward its goals of improving patient safety and reducing morbidity and mortality, the committee will coordinate with Risk Management to obtain information relating to patient safety from incident reports, patient complaints, patient claims. Proactive assessment of at least one high-risk process is conducted annually based on information from internal and external sources. Proactive assessment will be conducted utilizing FMEA or another acceptable process improvement methodology.

Patient Safety Educational and Research Activities

The orientation process emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing in-service and other education and training programs emphasize specific job-related aspects of patient safety. As appropriate, this training incorporates methods of team training to foster an interdisciplinary, collaborative approach to the delivery of patient care, and reinforces the need and way(s) to report medical/health care errors. The Patient Safety Committee shall plan and conduct educational activities in coordination with other educational efforts undertaken. In addition, the Patient Safety Committee will communicate issues of importance to clinical areas on a regular basis or when an issue is identified.

The safety of the health care delivery system is enhanced by the involvement of the patient, as appropriate to his/her condition, as a partner in the health care process. The comment card and patient satisfaction survey encourage the patient's participation and suggestions for changes in the system. Specific attention is directed at educating patients and families about their role in helping to facilitate the safe delivery of care.

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		Saved As:	Patent Safety Plan
PATIENT SAFETY PLAN			
Subject:	**PATIENT SAFETY PLAN**	Formulated:	**2009**
Manual:	**ADMINISTRATIVE MANUAL**	Reviewed:	**DEC. 2013**
Approval: PS, PI , MEC, Governing Board	Date:	Revised:	**June 2015**

I.   INTRODUCTION

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.

II.   PURPOSE

Our goal is to establish a proactive approach to prevent patient injuries and other medical errors in an open and non-punitive environment. The Patient Safety Plan is to assure that a planned, systematic, coordinated approach exists to improve patient safety and reduce risk to patients through an environment that includes.
- Integration of all patient-safety activities both existing and newly created
- Identifies focus of accountability and support within the leadership of the organization
- Involves patients, their families, staff and leaders in the identification and management of actual and potential risks to patient safety as well as opinions, needs and perceptions of risks to patients and suggestions for improving patient safety
- Recognizes acknowledgment of risks to patient safety and medical / healthcare errors
- Initiates actions to reduce these risks
- Internally reports of what has been found and the actions taken
- Focuses on processes and systems rather than individual blame and retribution
- Ongoing proactive reduction in medical / healthcare errors
- Considers patient safety priorities in the design and redesign of all relevant organization processes, functions and services
- Communicates to patients and when appropriate to their families about the outcomes of care, including unanticipated outcomes
- Educates patients and families about their role in helping to facilitate the safe delivery of care
- Ongoing orientation, in-service and other education and training programs to emphasize specific job-related aspects of patient safety to maintain and improve staff competence.

The Patient Safety Plan involves all departments and disciplines at all levels of Hospital in establishing the processes and mechanisms that comprise the patient safety activities through the recognition and acknowledgment of risks, preventive actions to reduce risk, internal reporting and corrective actions taken and fostering a non-punitive environment when errors occurs.

Proactive identification and management of potential risks to patient safety have the obvious advantage of *preventing* adverse occurrences, rather than simply *reacting* when they occur. This approach also avoids the barriers to understanding created by hindsight bias and the fear of disclosure, embarrassment, blame, and punishment that can arise in the wake of an actual event.

III. SCOPE OF ACTIVITIES

A. Saint Mary's Regional Medical Center 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 least quarterly. 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.

IV. DEFINITIONS

Error	An unintended act, either of omission or commission, or an act that does not achieve its intended outcome. A failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems.
Patient Safety	The degree to which the risk of an intervention and risk in the care environment are reduced for a patient while under the treatment of a healthcare provider or facility.
Patient Safety Event	Any identified defect, error, medical accident, near miss, sentinel event, medication error, significant procedural variance, or other threat to safety that could result in patient injury.
Medical Accident (Error)	An unintended event in the system of care with actual or potentially negative consequences to the patient. Types of medical errors: - Diagnostic errors (misdiagnoses leading to an incorrect choice of therapy or treatment, failure to use an indicated diagnostic test, misinterpretation of test results, failure to properly act on abnormal test results) - Equipment failures (defibrillator without working batteries, or inadvertent dosing of medications in a short time frame due to IV pumps with valves that are easily dislodged) - Infections (HAI, post-op wound infections) - Blood transfusion-related injuries - Deaths due to seclusion / restraint use
Medical Accident, "near miss"	Any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. May include a clinical event.
Sentinel Event	An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would be a significant chance of serious adverse outcome.
Root Cause Analysis	A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

Intensified Analysis	An examination of factors or elements that contribute to undesirable trends in performance to determine where best to focus changes for improvement.
Adverse Drug Event	A patient injury resulting from a medication, either because of a pharmacological reaction to a normal dose or because of a preventable adverse reaction to a drug resulting from an error.
Medication Error	Any preventable event that may cause or lead to inappropriate medication use or patient harm.
Hazardous condition	Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) which significantly increased the likelihood of a serious adverse event.

V.   AUTHORITY AND RESPONSIBILITY

Governing Board

The Hospital Governing Board has the ultimate authority and responsibility for approving the patient safety program. The Governing Board has delegated the responsibility of implementing an organization-wide patient safety program and creating a **"culture of safety"** to the leaders and medical staff of the hospital.

CNO / Administrator

The CNO / Administrator is responsible for assuring that this program is implemented, supported, and evaluated throughout the organization. As such, the CNO / Administrator will establish the structures and processes necessary to accomplish this objective. The CNO / Administrator delegates the day to day implementation and evaluation of this program to the Patient Safety Officer supported by the Director / Manager, Performance Improvement.

Director / Manager, Performance Improvement in conjunction with Patient Safety Officer

The Patient Safety Officer is responsible for the day to day implementation and evaluation of the processes and activities noted in this program. The Patient Safety Officer will work collaboratively with the Director / Manager of Performance Improvement in establishing the Patient Safety framework and a culture of patient safety.   The leadership including the CNO / Administrator, Risk Manager and the Chief of Staff will provide support as needed to assure the Patient Safety Plan is fully implemented and effective in positively impacting patient safety issues.

Duties shall include:
1. Supports Patient Safety Committee by collecting and formulating relevant information to facilitate decision-making activities.
2. Selects at least one high-risk patient safety process for proactive risk assessment (FMEA) at least every 18 months. Coordinates the process throughout this period.
3. Presents Patient Safety reports to all departments.
4. Extracts and trends data from various internal and external databases, (i.e., Joint Commission sentinel event alert information, Core Measure performance findings, occurrence reporting information from state and federal sources and current literature) for the use and review by Patient Safety and the Performance Improvement Committee.
5. Develops, and recommends new policies and procedures for patient safety based on analysis of data from events, and other relevant information.
6. Works in conjunction with the EOC Chair to prioritize risks, review and analyze data and performs risk analysis.
7. Maintains the confidentiality and legal privilege, as appropriate, of all data and information.
8. Facilitates patient safety orientation and in-service education programs.
9. Utilizes the hospital's performance improvement model, to coordinate the redesign of 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. Follows critical analysis and identification of failure mode (process variation) methodology.
10. Measures and evaluates effectiveness of patient safety program using the established goals and prepares an annual report for the Governing Board.

11. Assists department directors and administrators in enforcing policies and procedures, standards of care.

Directors and Managers
1. The leaders of the organization maintain responsibility for proper collection and dissemination of information for continuing education pertaining to the Patient Safety Program to employees.
2. The leaders create an environment that encourages prompt error identification and reduction and minimizes blame or retribution against individuals involved in an error or the reporting of an error.
3. The leaders provide direction and resources to conduct proactive correction and reversal of conditions and procedures that increase the chance that a patient might be harmed.
4. The leaders will collaborate in decision making which effects the development of hospital-wide patient care programs; policies and procedures that describe how patient care needs are met.
5. The leaders will assist in the development and implementation of the Hospital Plan for the Provision of Care, Performance Improvement Plan, Risk Management Plan, Information Management Plan, decision-making structures and processes; and implementation of an effective and continuous program to measure, assess and improve performance and patient safety.

(Directors and Managers defined as those accountable for leadership, planning, organizing, developing, controlling, directing and evaluating care for designated departments – "Provision of Care Plan".)

Medical Staff
The Chief of Staff and Department Chairs of the organized medical staff through the Medical Executive Committee and in collaboration with the leaders of the organization promote and support the patient safety initiatives of Saint Mary's Regional Medical Center.
(Medical staff defined as those physicians, surgeons and podiatrists who have been granted recognition as members of the medical staff pursuant to the terms of the Medical Staff Bylaws.)

Performance Improvement / Risk Management Committee
Performance Improvement / Risk Management Committee is assigned to oversee Patient Safety Committee at Hospital. Duties include:
1. Initiate evaluation of errors, trends, evidence-based proposals, typically ranging from no-harm, frequently occurring events to sentinel events with serious adverse outcomes.
2. Patient flow issues and the impact processes have on patient safety
3. Review and recommend approval of Patient Safety Plans
4. Review all sentinel event / root cause analyses and intensified analyses
5. Review and submit recommendations related to Sentinel Event Alerts
6. Analyze Risk Incident Occurrence and take actions to improve patient safety, in response to both actual and potential occurrences.
7. Provide annual recommendation of Patient Safety Plan
8. Recommend at least annually an area for proactive risk assessment

Patient Safety Committee
The hospital has an organization-wide, integrated patient safety program which operates under the Patient Safety Committee. It is the responsibility of the Patient Safety Committee to implement a hospital-wide patient safety program. The Patient Safety Committee is chaired by the Patient Safety Officer who is tasked to manage the day to day operations of the patient safety program.
The scope of the patient safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events. All departments, programs, and services within the hospital participate in the patient safety program. As part of the patient safety program, the hospital creates procedures for responding to system or process failures.
Patient Safety Committee:
1. Provide regular reports to the PI / RM and Environment of Care Committee.
2. Implement and monitors the National Safety Goals compliance within the facility.

National Patient Safety Goals: 2013

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.
> **NPSG.03.06.01**
> Maintain and communicate accurate patient medication information.

Goal 6 - Improve the safety of clinical alarm systems
> **NPSG.06.01.01**
> Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety.

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).

Goal 15 – The organization identifies safety risks inherent in its patient population.
> **NPSG.15.01.01**
> Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
> Address the patient's immediate safety needs and most appropriate setting for treatment.
> When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

Universal Protocol
> **UP.01.01.01**
> Conduct a pre-procedure verification process.
> **UP.01.02.01**
> Mark the procedure site.
> **UP.01.03.01**
> A time-out is performed before the procedure.

VI.   REPORTING MEDICAL / HEALTHCARE ERRORS

A. Reporting Policy
In order to achieve success in creating a safe environment for our patients, Saint Mary's Regional Medical Center will endeavor to create an environment in which it is safe for caregivers to report and learn from errors. To promote openness, the organization shall ensure that all reported mistakes be handled without threat of punitive action. It is recognized, however, that in certain cases, disciplinary action may be necessary.
The hospital recognizes that most clinical incidents result from a failure of systems. Our goal is to identify and record errors with the intent of continual process improvement.
All incidents, especially clinical errors, must be reported immediately.

B. Unusual Occurrence / Risk Incident Reporting
1. Inherent in the success of any patient safety program is the accurate and timely reporting of medical / healthcare errors and occurrences. This is accomplished through the established risk management mechanism of unusual occurrence / risk incident reporting which is geared to seeking out the "why" rather than the "who".
2. The "Risk Incident Reporting" policy and procedure details the process for reporting. Reference is made to the policy and will not be detailed as part of this plan. All employees, physicians and volunteers are trained and required to report suspected or identified medical / healthcare errors.
3. When a medical / healthcare error is identified, 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 any necessary interventions to contain the risk to others
    - Contact the attending physician and/or other physicians as appropriate to report the error, carrying out any physician orders as necessary, if licensed to do so
    - Preserve any information related to the error, including physical information such as blood unit bags, medication vials and labels, pumps and other devices
    - Complete appropriate documentation according to organizational policy in the medical record
    - Complete an Risk Incident Report in addition to reporting the error to the immediate Director or Manager as appropriate
    - Any Director / Manager receiving a report of a possible sentinel event or "near miss" will assure that the Director / Manager Performance Improvement and CNO / Administrator (Risk Manager) are promptly notified per the Sentinel Event Policy to determine status of the event.
4. Staff response to medical /healthcare errors are dependent on both the type of error identified and the actual or potential harm to the patient. All errors including "no harm" errors must be reported. The trending of unusual occurrence / incident reporting data over time is useful in identifying and correcting systems and processes before patient safety is compromised. Even a "no harm" error if found to be repetitive and organization-wide, will eventually result in a patient injury at some point in time if not corrected.
5. Medical / healthcare errors and occurrences will be reported internally and externally according to hospital policy and through the established mechanisms defined in such policy. Any external reporting will be initiated by the CNO/ Administrator in accordance with all state, federal and regulatory agency rules, laws and requirements.

C. Adverse (Never) Events: "Adverse (Never) event" includes any of the following:

1. SURGICAL OR INVASIVE PROCEDURE EVENTS
    o Surgery or other invasive procedure performed on the wrong site
    o Surgery or other invasive procedure performed on the wrong patient
    o Wrong surgical or other invasive procedure performed on a patient
    o Unintended retention of a foreign object in a patient after surgery or other invasive procedure
    o Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient
2. PRODUCT OR DEVICE EVENTS
    o Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting

- o 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
- o Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

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

4. CARE MANAGEMENT EVENTS
- o 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)
- o Patient death or serious injury associated with unsafe administration of blood products
- o Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
- o (NEW) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
- o Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- o Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
- o Artificial insemination with the wrong donor sperm or wrong egg
- o (NEW) Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
- o (NEW) Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. ENVIRONMENTAL EVENTS
- o Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
- o 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
- o 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
- o 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 -(NEW) 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

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- Abduction of a patient/resident of any age
- Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
- 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

(7) An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

(c) The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.

(d) "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

(e) Nothing in this section shall be interpreted to change or otherwise affect hospital reporting requirements regarding reportable diseases or unusual occurrences, as provided in NRS 439.843 of Title 40-Public Health requiring hospitals to report "unusual occurrences" and consider amending the section to enhance the clarity and specificity of this hospital reporting requirement.

Please refer to Adverse Event Reporting policy for reporting Adverse Events to the Department of Public Health.

D. Sentinel Events
The established organization policy on the management of sentinel events will determine the organizational response to medical / healthcare errors and occurrences. All sentinel events and "near miss" occurrences will have a Root Cause Analysis conducted. Included in the RCA process is the identification of specific risk reduction strategies to prevent recurrence with assigned responsibilities and time frames for completion and implementation.

VII. PERFORMANCE TO ENSURE PATIENT SAFETY

A. Proactive Risk Assessment (Failure Mode and Effects Analysis). An FMEA will be conducted on at least once every 18 months on one high-risk, high / low volume or "error prone" process. 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:
- The perceptions of risk to patients and suggestions for improving care
- The level of staff reluctance to report errors in care

B. Performance measurement data will be collected, aggregated, and analyzed to determine if opportunities to improve safety and reduce risk are identified. If so, the organization will prioritize those processes that demonstrate significant variation from desired practice, and allocate the necessary resources to mitigate the risks identified.

1. Assess the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation.
2. For each undesirable variation, identify the possible effects on patients, and how serious the possible effect on the patient could be (criticality of the effect).
3. For the most critical effects, conduct a root cause analysis to determine why the variation leading to that effect may occur.
4. Redesign the process and/or underlying systems to minimize the risk of that variation or to protect patients from the effects of that variation.
5. Test and implement the redesigned process.

6. Identify and implement measures of the effectiveness of the redesigned process.
7. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

C. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.

D. When processes, functions, or services are designed or redesigned, patient safety will be considered as part of the planning and implementation process.

E. 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).

VIII. **DATA COLLECTION AND RISK ASSESSMENT**
In order to reduce the likelihood of patient incidents and negative outcomes, Hospital shall track the frequency and type of medical errors and compile them in order to learn from and prevent future negative occurrences.

A. Data Sources
   1. Internal
      - Risk incident reports with database compilation
      - Adverse Drug Events and Adverse Drug Reactions
      - Data from patient complaints
      - Risk Management and Safety findings
      - Compliance findings
      - PI and special study findings
      - Infectious Disease information per NRS 449.865
      - Operative/Invasive procedure, blood use, autopsy, restraint reviews
      - Morbidity/Mortality review findings
      - Departmental indicators
      - Employee surveys (includes perception of risk)
   2. External
      - Joint Commission Sentinel Event Alerts
      - Core Measures Indicators
      - Accreditation / regulatory deficiencies
      - Patient Satisfaction Surveys
      - Other Evidence-Based external sources

B. 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).

C. 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.

D. 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.

E. PDCA (Plan, Do, Check, Act) methodology for Performance Improvement will be utilized for all performance improvement activities within the facility.

IX.   PATIENT, STAFF AND HEALTHCARE PRACTIONER EDUCATION

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, including providing information about their health status, and asking questions when they do not understand information provided to them.

a) Staff and HCP's will receive education and training on Patient Safety processes during their initial orientation process and annually regarding specific job-related aspects of patient safety, including the need and mechanism to report medical / healthcare errors, actual and potential adverse events and preventable healthcare associate infections. Ongoing in-service and other education provided will assist in the maintenance and improvement of staff competence and will support an interdisciplinary approach to patient care.

X.   TUBING MISCONNECTIONS

Tubing and catheter misconnection errors are an important aspect of Patient Safety at Hospital. Given the potential for life threatening consequences, Hospital is committed to increase awareness and analyze these errors, including averted errors, to promote patient safety.

Saint Mary's Regional Medical Center follows the recommendations and strategies below to reduce tubing misconnection errors:

A. Strict guidelines will be followed to prevent purchase of non-intravenous equipment that is equipped with connectors that can physically mate with a female luer IV line connector.
B. Acceptance testing will be conducted (for performance, safety and usability) and, as appropriate, risk assessment (e.g., failure mode and effect analysis) on new tubing and catheter purchases to identify the potential for misconnections and take appropriate preventive measures.
C. Appropriate Staff will be oriented and trained on:
   a. Tracing a tube or catheter from the patient to the point of origin before connecting any new device or infusion.
   b. Rechecking connections and tracing all patient tubes and catheters to their sources upon the patient's arrival to a new setting or service as part of the hand-off process.
   c. Routing tubes and catheters having different purposes in different, standardized directions (e.g., IV lines routed toward the head; enteric lines toward the feet). This is especially important in the care of neonates.
   d. Informing non-clinical staff, patients and their families that they must get help from clinical staff whenever there is a real or perceived need to connect or disconnect devices or infusions.
   e. For high-risk catheters (e.g., epidural, intrathecal, arterial), label the catheter and do not use catheters that have injection ports.
   f. Never use a standard luer syringe for oral medications or enteric feedings.

XI. CULTURE OF SAFETY SURVEY

Saint Mary's Regional Medical Center will conduct at least annually a survey to assess its Culture of Safety. The Hospital Survey on Patient Safety Culture is designed to measure four overall patient safety outcomes:
- Overall perceptions of safety
- Frequency of events reported
- Number of events reported
- Overall patient safety grade

Saint Mary's Regional Medical Center will utilize the Agency of Healthcare and Research Quality (AHRQ) research survey that is intended to measure the ten dimensions of culture pertaining to patient safety:
1. Supervisor/manager expectations & actions promoting patient safety
2. Organizational learning – continuous improvement

3. Teamwork within units
4. Communication openness
5. Feedback & communications about errors
6. Non-punitive response to error
7. Staffing effectiveness
8. Hospital management support for patient safety
9. Teamwork across hospital units
10. Hospital handoffs & transitions

The results of the survey will be used by the Patient Safety Committee to enhance the patient safety program at Hospital.

XI.   PLAN EVALUATION

A. This plan encompasses many disciplines and activities in addition to those specifically referenced in the plan. The Patient Safety Plan is designed to assist in the integration of these activities, not replace them. Integration should enhance the accountability and impact of the patient safety related activities and collectively provide a comprehensive patient safety management system for Saint Mary's Regional Medical Center.

B. The Patient Safety Plan should be considered a "working" documented and an interim product to facilitate the development of a "culture of safety". As such, the plan may be modified as the implementation of the patient safety standards takes place and sections of the plan are incorporated into existing plans, policies, procedures and protocols.

C. The Patient Safety Plan will be reviewed on an annual basis. Goals shall be identified and prioritized based on internal occurrences and trends, RCA, FMEA, survey results, National Patient Safety Goals, Sentinel Event Alerts, State and Federal regulations, medication safety strategies and other applicable safety initiatives.

REFERENCES:
- Joint Commission Patient Safety Standards
- Joint Commission Sentinel Event Alerts
- Sentinel Event policy
- Performance Improvement Plan
- Risk Management Plan
- Environment of Care Plan
- Plan for Providing Patient Care
- Occurrence / Risk Incident Reporting policy
- Infection Prevention Plan
- Nevada Department of Health and Human Services
- NRS 439.843
- NRS 439.865

Approvals

_____   _____
Director / Manager Performance Improvement   Date

_____   _____
Chief Nursing Officer / Administrator   Date

_____   _____
Chief Executive Officer   Date

_____   _____
Chairman, PI Committee   Date

_____   _____
Chief of Staff   Date

_____   _____
Governing Board   Date

SEVEN HILLS HOSPITAL

2015 Patient Safety Plan

"The key to reliable, safe care does not lie in exhorting individuals to be more careful and try harder. It lies in learning about causes of error and designing systems to prevent human error whenever possible" (IHI, 2008, p. 19). [i]

Mission Statement

Seven Hills Hospital

"It is the Mission of Seven Hills Hospital to improve the quality of life for our patients, their families and communities by providing consistently excellent and compassionate behavioral health and substance abuse treatment services."

Patient Safety

Through a robust Patient Safety Program, the Patient Safety Committee fulfills its commitment to aiming for the elimination of medical errors through the use of best practice and setting the standards of excellence of quality mental health care.

Guiding Principles

The Patient Safety Plan is a conceptualized model of care founded on the belief that a just culture holds the key to a patient safety focused organization. Seven Hills Hospital supports a just culture and focusses on analyzing structural, process, and outcome measures and using an evidence-based approach to support interventions.

Data and safety monitoring is a system for auditing and analyzing outcome data from continuous research. The Patient Safety Committee provides guidance for clinical staff while confirming compliance to organizational goals of providing a safe and therapeutic environment that enhances recovery. Patterson (2011) reported on an innovative quality improvement success describing an interview with an Infection Prevention Coordinator, who credited their success in overcoming communication barriers by stating that "if workers own the solutions and share them with their colleagues, the solutions are adopted a lot better than if someone from Infection Control comes in and tells them they have to do things a certain way" (p.22). Similarly, the Patient Safety Plan operates on the premise that front-line staff are untapped resources with the ability to influence peers towards best practice.

Seven Hills Hospital Strategic Goals for 2015

See Attached.

Performance Improvement & Risk Management Strategic Goals & Objectives for 2015

Enhance Overall Competency/Quality of Staff, Particularly in the Realm of Effective and Therapeutic Interactions and Interventions with Patients

- Support the delivery of evidence based practice training and research utilization among staff.

- Develop a program offering training for staff in high priority areas supporting patient safety.

Promote the Culture of Safety

- Improve the dissemination of safety related efforts across the organization readily.
- Enhance the Patient Safety Committee transitioning to a more active committee with monthly meetings.

Promote Compliance with the National Patient Safety Goals

- 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.
- 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.
- 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.
- Find out which individuals served are most likely to try to commit suicide.

Responsibility

All staff employed or contracted through Seven Hills Hospital are responsible for knowledge of policies and procedures. This plan supports the staff compliance towards established policies and procedures. Staff supervisors work alongside front-line staff to identify deviations from policy, procedures, or standards and promptly resolve errors. In addition, opportunities for enhancing or policies or procedures are identified and routed through the Patient Safety Committee or the Patient Safety Officer.

In a culture of safety, each staff member is a provider of service—the consumer is both the patient and organization. Staff provide services with safety in mind. The organization is provided with an environment rich in safe practices and ultimately benefits all patients and staff receiving best practices.

Sullivan et al. (2011) suggests patient safety to begin with prevention of adverse events. Preventable adverse events are often the result of missing systems, checks and balances, or failure to comply with existing systems designed to catch and prevent these adverse events as demonstrated in Figure 1. Staff work together to promote safety awareness across the organization and influence policy and procedures through supporting resiliency and risk reduction efforts.

Hazards

Figure 1. Active failures and latent conditions cause adverse events. Based on the "swiss cheese" model by J. Reason.

Patient Safety Committee

The Patient Safety Committee consists of a Physician, a member of the Executive Staff, the Director of Performance Improvement and Risk Management/Patient Safety Officer, Infection Control Officer, Pharmacist, and front-line staff. Data is received, analyzed, processes and problems identified, and prioritized depending on the urgency of needed interventions. Problems deemed outside the scope of the Patient Safety committee will be sent to other committees for collaboration or referrals.

The Infection Control Officer reports to the Patient Safety Committee and works alongside to reduce or eliminate threats to patient care involving organisms. See Infection Control Plan.

Agency for Healthcare Research and Quality. (2008). Patient safety culture surveys. Retrieved from www.ahrq.gov/qual/patientsafetyculture

Institute for Healthcare Improvement. (2007). *5 million lives campaign how-to guide: Governance leadership.* Cambridge, MA: Author.

Patterson, P. (2011). Looking to front-line clinicians, staff for lasting improvements. OR Manager, 27(5), 22.

Sullivan, M., Robertson, G., & Nibbelink, S. (2011). *How an intelligent infrastructure can help optimize hospital safety and security.* North Andover, MA: Schneider Electronic.

World Health Organization. (2012). 10 facts on patient safety. Retrieved from www.who.int/features/factfiles/patient_safety/patient_safety_facts/en

PATIENT SAFETY COMMITTEE

	POLICY NO:
SUBJECT: Patient Safety Plan	**PAGE NO: 1 of 8**
	EFFECTIVE: 11/2002
	REVISED:12/2011
CROSS: Medical Staff	**APPROVED:**

POLICY: South Lyon Medical Center Patient Safety Plan

PROCEDURE:

1. The Medical Staff, with the approval of the Governing Board shall develop and implement a Patient Safety Plan to encompass all facets of patient care at South Lyon Medical Center. This includes Acute Care, Long Term Care and Rural Health Clinics.

2. The Medical Staff will appoint and submit to the Governing Board for approval the implementation of a Patient Safety Committee which will comprise at a minimum: a physician, a nurse, pharmacist, governing board member and risk manager. This committee shall:

   a. function under the authority of the Medical Staff
   b. meet monthly
   c. investigate, report and formulate corrective actions related to alleged sentinel events
   d. review medical equipment/devices safety and maintenance inspections
   e. review and recommend actions related to medication events
   f. review and investigate patient care related incident reports
   g. review, investigate and recommend corrective actions for near-miss events
   h. additional tasks as assigned by the Medical Staff

3. The Administrator shall appoint a Patient Safety Officer whose responsibilities are outlined in the position description.

4. The Patient Safety Plan shall include but not limited to the following items:

   I. General:

   a. Patient Safety involves a variety of clinical and administrative activities that health care organizations undertake to identify, evaluate, and reduce the potential for harm to beneficiaries and to improve the quality of health care. Effective medical/health care error reduction requires an integral approach and a supportive environment, in which patients, their families, organization staff and leaders can identify, manage and learn from actual and potential risks.

   b. A successful patient safety program facilitates non-punitive, interdisciplinary approach to decrease unanticipated adverse health care outcomes. The organizational focus is on continued learning about risks and mitigation strategies and reengineering systems/processes to reduce the chance of human error. South Lyon Medical Center (SLMC) fosters and

supports an organizational environment that recognizes and acknowledges potential risks to patient safety and the occurrence of medical/health care errors. The patient safety program encourages medical error reporting in order to identify system or process failures and to enhance improvement strategies.

II. South Lyon Medical Center (SLMC) Patient Safety Program

a. The goal of the SLMC Patient Safety Program is to reduce the chance that the adverse effects of human error will harm patients. By creating and promoting a culture in which staff willingly report actual and near-miss patient safety related events without fear of disciplinary action, SLMC is encouraging these events to be freely identified. Once events have been identified, systems and processes can be analyzed and improved in order to prevent future recurrence. Improved systems and processes result in a safer patient care environment.

b. SLMC Patient Safety Program focuses on system and process design rather that 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 requires that an investigation be conducted to determine the cause(s) of the adverse event.

d. A patient safety event that causes no patient harm requires no standard of care determination. However, any patient safety event that results in patient harm or potential patient harm, by definition, is a PCE. The patient safety officer will be notified of all PCE's and these will be managed according to the established policies and procedures outlined in the Patient Safety Committee. Given the results of the investigation of the event, a Standard of Care determination will be required. Competency related information that arises through patient safety investigations will not be released outside of the Patient Safety Program except as noted in paragraph e below. The Patient Safety Program will consider process/system issues, while the Standard of Care determination reviews the individual's performance.

e. Although not a specific focus of the Patient Safety Program, concerns about a specific provider's/professional's competence may arise. Competence relates directly to an individual and, as such, requires an evaluation of the provider's/professional's performance, not an evaluation of the health care system. Competence will be addressed through the organization's competence assessment, credentialing and privileging process. No individual competence related information will be released outside of the Patient Safety Program, except as noted in paragraph f below. If the competence assessment processes are determined to require review and improvement, such recommendations by the Patient Safety Committee and Medical Staff may be appropriate.

f. The vast majority of errors are unintentional. No disciplinary action will be initiated against the individual(s) involved in an unintentional error. However, certain events, such as noted below, do warrant administrative, disciplinary or legal action. Should any of the following be discovered in the course of a patient safety event investigation, the Administrator and Medical Staff will be immediately informed of the circumstance and action taken beyond the scope of the Patient Safety Program:

1) Criminal activity (e.g. assault and battery, etc)
2) Intentional unsafe acts due to gross negligence or reckless behavior

3) Alleged patient abuse of any kind
4) Impairment due to medical and psychological conditions including alcohol or other drug abuse.

III. South Lyon Medical Center Patient Safety Function.

a. Integration of all patient safety related issues and processes under the auspices of a single committee/ functional team. This reduces duplication of effort and enhances program efficiency.
b. Patient Safety Committee.

1) Membership. Membership is outlined in NRS 439.875; 1) The infection control officer, 2) The patient safety officer, 3) At least three providers of health care who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility. And 4) One member of the executive or governing body of the medical facility.
2) Chairperson. The chairperson shall be a nurse or physician.
3) Committee minutes/reports. The committee minutes/reports will summarize the organizations patient safety activities to include, as a minimum:
   a. Analysis of all clinical and non-clinical reported events, trends and lessons learned.
   b. Actions necessary for organizational process/systems improvements as appropriate.
   c. Proactive patient safety error reduction activities.
   d. Progress related to risk assessments, prospective analysis and root cause analysis action plan implementation and effectiveness, according to established time lines.
   e. Patient Safety Committee minutes/reports will be forwarded to the Medical Staff Committee. Quarterly reports will be forwarded to the Governing Board. Recommendations associated to patient safety will be forwarded to the Medical Staff for implementation as appropriate.

c. Management of Patient Safety Information.

   a. The focus of patient safety data collection and reporting is to improve organizational systems and to provide the safest care possible. The information and data amassed through reporting, investigation and evaluation will be confidential and reported through the Medical Staff Quality Assurance process.
   b. Data trend analysis will include, but not be limited to, the following:
      1) Sentinel Events or actual or alleged.
      2) Medication errors and fall.
      3) Equipment malfunctions.
      4) Preventive/corrective interventions
   c. Ad hoc committees may be assigned by the Medical Staff regarding competency investigations related to a patient safety related event to insure that peer status is maintained throughout any investigation. All information obtained will remain confidential under the auspices of Medical Staff Quality Assurance.

IV. Patient Safety Event Management.

a. Event identification. A patient safety event is any incident that occurred (actual event) or almost occurred (near miss) that caused or had the potential to cause harm to a patient. Identification and reporting of near misses and adverse events, including those that result from practitioner/professional error, should be encouraged as an expectation of everyday practice. The three types of patient safety events include near miss, adverse events and sentinel events.

b. Near Miss. A near miss is an event or situation that could have resulted in harm to a patient, but did not, either by chance or through timely intervention. The event was identified and resolved before reaching the patient. Because near misses generally occur more frequently than actual adverse events, proactive analyses of near misses provide a tangible opportunity to improve the system without having to experience an actual adverse event. Staff should be encouraged to report near miss events for the purpose of analysis and identification of methods improvement.

c. Adverse Event. An adverse event is an occurrence associated with the provision of health care or services that may or may not result in harm to the patient. Adverse events may be due to acts of commission or omission. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no harm or permanent effect to the patient.

d. Sentinel Event. A sentinel event is an unexpected occurrence involving death, serious physical or psychological injury, or the risk thereof. **Recent Nevada Legislation has expanded the definition of a Sentinel Event to include Surgical Site Infections (SSI's), Catheter Associated Urinary Tract Infections (CAUTI's). A comprehensive listing of potential Sentinel Events is included in the Sentinel Event Reporting Guidance Compliance Manual dated 12/606/2011. Serious injury** specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and proactive response on the part of the organization.

V. Event Documentation and Reporting.

1. Prevention of harm to patients is everyone's responsibility and reporting all potential and/or actual patient safety events is a performance expectation of all organizational staff. Anyone with knowledge of a patient safety event not only may, but should, report it.

a. Immediate actions.

1) Upon identification of a actual patient safety event, the staff member will immediately perform necessary health care interventions to protect and support the patient's clinical condition. The patient's attending physician and other physicians, as appropriate, will be contacted as soon as possible to report the incident and provide an update on the patient's current clinical status.

2) As appropriate to the event, the staff will initiate all physician directed orders and take other necessary health care interventions to contain the risk to others, and to preserve event-related materials that may require further investigation. Examples of physical information preservation include: removal and preservation of a blood unit for a

suspected transfusion reaction; preservation of IV tubing, fluid bag, and/or IV pump for a patient with a severe drug reaction from a IV medication. Preservation of information also includes documenting the facts regarding the event in the patient's medical record according to organizational policy and procedure.

3) If the patient safety event involves serious physical or psychological injury, unexpected death, or qualifies as a sentinel event, the appropriate department director will be notified immediately. If such events occur after hours, the administrative on-call staff will be notified immediately.   Individuals notified will ensure proper notification of senior management is accomplished in a timely fashion.

b. Documentation and Internal Reporting.

1) Any individual in any department who identifies a potential (e.g.near-miss) or actual patient safety event will immediately notify their immediate supervisor and will initiate a Incident Report. This report will contain concise, factual, objective and complete details about the event.

2) Incident Reports or in the case of medication errors, a Adverse Drug Event Report will be forwarded to the department director within 24 hours of the discovery of the event or the first duty day following a weekend or holiday. The department director will review the report, add any additional relevant information, and forward it to the Patient Safety Officer, or designee, within 24 hours of receipt.

3) The Patient Safety Officer (PSO), or designee, will review all incident reports and ADE reports.   In addition, the PSO will determine what specific actions are necessary to further evaluate the event. If the event is a sentinel event, the PSO will immediately notify the Administrator and Risk Manager and activate a Root Cause Analysis Team from the Patient Safety Committee and others as deemed appropriate to investigate the event.

4) If the patient safety event is an intentional unsafe act that results from gross negligence or possible criminal activity, the event shall be reported to the appropriate authorities for investigation.

5) Some events fall within the definition of both an adverse event and an intentional unsafe act. For example, infant abduction would be both a crime and a reportable Sentinel Event that require Root Cause Analysis. In cases that appear to be both a adverse event and an intentional unsafe act, primary authority and responsibility for dealing with the event belongs to the Administrator and Risk Manager. This is beyond the scope of the Patient Safety Program. The PSO will coordinate a review of the systems and processes implicated in the actual or potential unsafe act, to include conducting a root cause analysis, if applicable, but will defer to a separate investigation with respect to the culpability of any persons involved in the event.

6) External reporting requirements. All incidents meeting the definition of a Sentinel Event must be reported to the State Health Department

and Bureau of Licensure. Reports must be completed within the time frame as outlined in policy and procedure.

VI.   Patient Safety Event Analysis.

Event analysis assists in the discovery of the root causes and/or contributing factors associated with the patient safety event. Tracking and trending of data allows the Patient Safety Committee and Medical Staff to identify familiar trends or circumstances so that system or process issues can be identified and improved.

a. Aggregate review analyses. Aggregate review consists of examining data elements for common trends or patterns within the group. The use of aggregated review serves two purposes. It allows for wider applicability of the analyses (i.e., trends or patterns that were not noticeable in an individual case analysis become more obvious as the number of cases increases). In addition, it more clearly defines specific data elements in a recurring problem and encourages prudent use of the time and expertise of the organization staff associated with evaluation and corrective action.

b. Root Cause Analysis. A root cause analysis must be conducted and an action plan completed for all actual sentinel events. The Patient Safety Committee will formally designate a root cause analysis team to conduct a thorough and credible root cause analysis on all sentinel events. A Root Cause Analysis (RCA) is the process for identifying the basic and/or contributing casual factor(s) associated with patient safety events. The review is interdisciplinary and includes those who are closest to the process, but typically not those directly involved in the specific event. Those directly involved may be consulted for event-related information if appropriate. The RCA focuses on systems and processes, not individual performance. It identifies changes that could be made in the systems and processes to improve performance and to reduce the risk of adverse events, or the recurrence of near misses, with the ultimate goal of reducing and/or eliminating patient harm.

c. Root Cause Analysis Action Plan. Once the RCA has been completed, a detailed action plan must be developed to enumerate the risk reduction strategies that the organization intends to implement to prevent the recurrence of similar events. The action plan should address responsibility for implementation, oversight, pilot testing (if appropriate), timeliness, and the specific metrics to be employed in evaluating the effectiveness of the actions taken.

d. The RCA action plan will be submitted to the Medical Staff for approval.

e. Follow-up review. All RCA action plans will be reviewed at a minimum of 6 months following implementation to address the effectiveness of the improvements implemented by the organization. These findings will be reported to the Medical Staff and Governing Board.

VII.   Patient Safety Event Communication.

Administration and all staff are reminded that all data compiled as part of the Patient Safety Program are QA information and protected from disclosure and must be marked as Quality Assurance Document.

a. Staff involved in a patient safety event. Any staff member reporting and/or directly involved in a patient safety event that caused patient harm will receive support and assistance from their supervisor to facilitate the staff member's professional and emotional needs related to the patient safety event. Management efforts and activities will focus on improving the systems and processes that may have contributed to the event rather than disciplining those involved.

b. Reporting a patient safety event. Staff members and supervisors who submit patient safety event reports will receive timely feedback on the actions being taken as a result of their report.

c. Patient/family affected by a patient safety event. In cases involving an unanticipated outcome of care, a qualified health care provider will inform the patient and/or his/her family member(s) within seven (7) days of discovery of the event. This information is provided as a matter of policy and does not affect any rights or obligations in legal or administrative proceedings. Under no circumstances will QA-protected information be released or provided to the patient/family member.

d. The Patient Safety Officer, or designee, is responsible to ensure that the provider and patient/family member communication takes place. The designated primary communicator will document in the patient's medical record what was communicated to the patient/family member, the patient/family member's response, and any other pertinent information. It shall be the responsibility of the affected patient's primary care physician or Chief of the Medical Staff or Vice Chief of the Medical Staff to make the initial and subsequent notification.

e. In most cases, facts surrounding the patient safety event that affect the patient can and should be disclosed to the patient/family member by the provider.

f. Any specific questions relative to disclosure of information associated with unanticipated adverse outcomes should be referred to the organization's legal representatives.

VIII   Patient safety Education and Training

a. All staff shall receive patient safety education and training during their initial new employee orientation and on an annual and as-needed basis, regarding job-related aspects of patient safety and staff specific roles and responsibilities to actively support patient safety policy.

b. Community education. Patients and potential patients/family members shall be educated concerning their role in helping to facilitate the safe delivery of care. Methods include but are not limited to; public forums, newspaper articles, addressing specific community groups and organizations.

c. **Checklists have been developed and implemented in several different formats that range from facility policies, department checklists and medical record audits. These checklists and policies include but are not limited to; correct patient identification and verification, foley catheter criteria, informing patients of Healthcare Acquired Infections (HAI's) or Facility Acquired Infections (FAI's), hospital inpatient information sheets related to HAI's and hand hygiene and respiratory etiquette and patient information regarding discharge planning, medication reconciliation and request that providers indicate the use or reason for each prescription that is issued.**

IX   Confidentiality of Medical Quality Assurance Information.

As with other medical QA documents, any information, records, reports, minutes, and other documents directly associated with patient safety activities are protected under 10 USC 1102. In discussing medical information with family members, staff shall also comply with other applicable restrictions on nonconsensual disclosures, including those under the Privacy Act, 5 USC 552a. As a general rule under the Privacy Act, information regarding a patient's condition shall not be provided to others without the patient's consent.

Southern Hills Hospital and Medical Center

Performance Improvement and Patient Safety Plan

Updated: May 13, 2015
Quality of Care Committee: 05/14/2015
Medical Executive Committee: 06/18/2015
Board of Trustee: 06/24/2015

TABLE OF CONTENTS

Southern Hills Hospital and Medical Center Performance Improvement Plan

I. SCOPE:

- Hospital wide.
- All patient services provided by our staff or through contracted services.
- Focus on indicators related to improved health outcomes and the prevention and reduction of unanticipated adverse events.
- Measurement of key processes and outcomes to understand and maintain stability; measure outcomes to help determine priorities for improving systems or processes.
- Provides for assessment of individual competence and performance when appropriate.
- Evaluates risk potential.
- Provides for process redesign to promote patient safety.
- This evaluation may include both measurement of frequently occurring events that do not result in harm but have risk potential, and singular events that may have serious adverse outcomes.
- Evaluates opportunities for process improvement and implements appropriate projects based on metric results or patient outcomes.

II.   PURPOSE:

This plan establishes our planned, systematic, hospital wide approach to process design and performance measurement, analysis and improvement. It also establishes our integrated organization wide Patient Safety Program.

In accordance with Nevada Revised Statute 49.265, Performance Improvement activities established in this plan are considered privileged and confidential.

III.   STRUCTURE: See attachment #1

The leaders of Southern Hills Hospital and Medical Center believe:
- Leadership and planning are essential to initiating and maintaining performance improvement and promoting a culture of patient safety.
- Performance improvement and proactive patient safety activities are most effective when all appropriate individuals and professions work collaboratively to plan and implement them.

A. Board of Trustees
The Board of Trustees is ultimately accountable for the safety and quality of care, treatment and services and has ultimate authority and responsibility to require and support a performance improvement program. The Board will have the responsibility to assure new processes are designed well and important processes and outcomes are continuously measured, assessed and improved. The Board delegates the authority and accountability for the operation of the program to the Southern Hills Hospital and Medical Center Administration, Medical Executive Committee, and the Quality Care/Patient Safety Committee.

The Board oversees this responsibility by:
- Approving the Performance Improvement / Patient Safety Plan.
- Receiving and reviewing reports summarizing the findings of the organizational performance activities and proactive Risk Assessment to promote patient safety on a routine basis.
- Receiving, reviewing and approving actions taken to improve care and promote patient safety.
- Participating in the selection of priorities for improvement and priorities for proactive patient safety. Priorities are based on:
    - o   Patient Safety

- o Strategic planning priorities
- o Needs identified for major patient populations served
- o Needs identified in operation processes
- o Need for new of modified services or processes
- o Patient care and organizational functions and
- o Overall available resources
- Annually receiving a summary report/presentation of Performance Improvement activities.
- Quarterly receiving a summary report/presentation of Patient Safety activities.
- Monthly receiving a Quality Care Committee Dashboard of Core Measures results, Clinical and Patient Safety Indicators.

B. The Medical Executive Committee:
The Medical Staff is committed to the pursuit of clinical excellence with appreciation for the cost of health care resources
- Approves the plan and design of Performance Improvement and Patient Safety activities.
- Participates in the selection of priorities for improvement and priorities for proactive patient safety.
- Systematically evaluates the hospital's performance activities of the departments, committees and functional teams by the review of minutes, reports, and inquiries directed to/from the departments or committees by the Medical Executive Committee.
- Ensures that care is provided by competent, qualified Medical Staff and Allied Health Staff through the continuous surveillance of the professional performance (OPPE and FPPE) of all members. When improvement activities lead to a determination that an individual with performance problems is unable or unwilling to improve, modification of the individual's clinical privileges, scope of services or other appropriate action will be taken.
- Notifying all providers of health care who provide treatment to patients of the existence of the approved plan and of the requirements of the plan.
- 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 e.g. allied health providers and provide information for the recredentialing process. The Medical Executive Committee also requires the Medical staff to maintain quality control programs, as appropriate.

C. Quality Care /Patient Safety Committee
The Quality Care/ Patient Safety Committee is responsible to the Board of Trustees, Medical Executive Committee and Administration for the overall operation of the Performance Improvement and Patient Safety Plan. This is an interdisciplinary committee that includes representatives from leadership, a member of the Board of Trustees, the CEO, the CNO, Directors, Medical Staff, Patient Safety Officer and staff-level members from nursing and ancillary areas. This committee receives performance improvement education and training when identified to ensure success of PI projects.
On an annual basis committee representatives will meet with the facility leadership to discuss the current Performance Improvement priorities, Patient Safety priorities and associated activities will be reviewed and evaluated. Recommended priorities will be presented to the Quality Care/Patient Safety committee for discussion/approval. Priorities will be added or changed as deemed necessary. The recommended priorities will then be forwarded to the MEC and Board of Trustees for discussion and approval. At least one high-risk process will be the subject of ongoing measurement and periodic analysis to determine the degree from intended performance at any given time.

The duties of the Quality Care/ Patient Safety Committee include:
- Direct the preparation of QCC Internal Reports and/or Patient Notifications for any quality of care issues.
- Coordinate, prioritize, and monitor Medical Staff data gathering and analysis of the hospital's performance improvement and proactive patient safety programs and coordinate the Medical Staff's activities in this area with those of the other professional and support services in the hospital.
- Assure the development, maintenance and execution of a Performance Improvement and Patient Safety Program that measures and compares the actual medical care delivered and promotes

patient safety.
- Maintain an objective, concurrent review methodology that determines the level of clinical practice through a scientific, investigative, corrective and educational approach as directed by the committee members as part of the ongoing internal processes of this committee.
- Review of the findings of the ongoing review process on a regular basis and make recommendations for further study or action in an effort to improve patient care and improve patient safety.
- Review of internal findings and recommendations from Quality Care Teams that have been mandated by the Committee.
- Oversee the maintenance of quality profiles for each Medical Staff and Allied Health member and request the transmission of the same to the Credentials Committee, Department Chairman, in connection with the periodic reappraisal of each member as part of the ongoing internal processes of this Committee.
- Make recommendations as needed to the Chief of Staff and Administration for educational offerings based on the findings of the Committee through its implementation of the Performance Improvement and Proactive Patient Safety Programs.
- Assure all medical and surgical services performed in the hospital are evaluated as they relate to appropriateness of diagnosis and treatment.
- Responsibility for effective operation of the patient grievance process as directed by the Governing Body. Review and analysis of aggregate data on a quarterly basis will accomplish oversight of the grievance process.
- The Board of Trustees has delegated to the Quality Care Committee the responsibility for resolving patient grievances. The Quality Care Committee will report grievance information to the Board of Trustees. Review and analysis of aggregate data on a quarterly basis will accomplish oversight of the grievance process.
- Oversight and priority setting for patient safety.
- This team will conduct proactive Risk Assessment through the review of Patient Safety indicators and reports from the Patient Safety Officer, Failure Mode and effect Analysis (FMEA), data collected regarding perceived risks of patients, families, and staff, review of literature, including Sentinel Event Alerts, Risk Watch, the Institute for Safe Medication Practices Medication Safety Alerts and other appropriate publications.
- This committee will evaluate the quality of measures carried out by the medical facility to reduce the number and severity of sentinel events.
- A report of any Sentinel Events will be presented at this meeting by the Patient Safety Officer on a monthly basis
- Annually, this team will review patient safety checklists that improve the outcome of patient's health and welcome in which are both clinical and non-clinical.
  - These checklists are related to treatments, room and environment sanitation, and discharge.
  - The minutes will reflect the effectiveness of these checklists or if changes are required to ensure patient safety.
  - It is this committee's responsibility to monitor and document the effectiveness of the checklists and to revise to assure current standards are met.
- Annual oversight of patient safety polices including 2 Patient Identifier policy, Hand Hygiene Policy, and ensuring compliance with patient safety checklists by annual review of each identified checklist.
  - To ensure compliance with checklists, quarterly spot-checks will be made by the department director or Quality Management Department.
  - This review of policies will be in place to ensure the most current standards in patient safety protocols are in place.

D. QCC/Patient Safety Performance Improvement Teams/Committees
Standing Committees are committees that have been appointed by the Medical Staff to assess and improve specific functions on a continuous basis. Representation on these committees is interdisciplinary and includes Department Directors, employees, and members of the Medical Staff

who are familiar with or affected by the function that is being addressed. These committees include:
- Bioethics/Patient Rights
- Stroke Committee
- Sepsis Committee
- Patient Falls Committee
- Chest Pain/STEMI/CV Committee
- HIM/Forms/Chart Review
- Infection Control
- Perinatal Taskforce
- Radiation Safety
- Utilization/Resource Management
- Pharmacy and Therapeutics
- Others as identified

Informal teams are designed by a director to work on a specific task using a team approach and problem solving tools within the departments. This type of team is very limited in scope. Employees at all levels are encouraged to participate.

E. Administration
Administration, through the Chief Executive Officer, is also responsible for the organizational performance and promotion of patient safety and is accountable to the Board of Trustees. The CEO authorizes the CFO, CNO and Quality VP to participate with the leaders of the Governing Body, Medical Staff, Nursing/Ancillary Directors and employee representatives to plan, design, measure, assess, and improve the performance of the hospital.

The duties of Administration include:
- The leadership develops and maintains the framework necessary to accomplish the organization's goals through proper direction, implementation, coordination, and to ultimately improve services, reduce risk, and promote patient safety throughout the hospital.
- In addition, Administration shall serve as either regular or ad hoc members of the Quality Care/Patient Safety Committee in the development of Quality Care Teams that will address, in prioritized order, the important house wide functions, systems, processes, and outcomes of care as recognized by our customers: patients, physicians, employees and the community. Patient safety concerns and issues are given a high priority.

F. Medical Staff
The Medical Staff is responsible to the Board of Trustees for maintaining a consistently high level of quality patient care, evaluating the clinical performance of all individuals with delineated clinical privileges and for monitoring and evaluating the quality of patient care delivered. As a part of the Performance Improvement and Patient Safety Programs, opportunities to improve care, reduce risk and promote patient safety will be addressed.

In accordance with the structure of the Medical Staff described in the Bylaws, all members will be assigned to a single department and will be responsible for reviewing Performance Improvement activities at Department/Committee meetings. The Chief of each Department is responsible for implementing and evaluating the quality of care and treatment delivered to all patients by the Department and the clinical performance of all individuals with clinical privileges in the Department. In the event that a process related issue is identified that impacts patient outcome or patient safety, interdisciplinary teams will be mobilized or established as deemed necessary. Members will be representative of the Medical Staff Departments involved, as well as, nursing or ancillary personnel as required to efficiently address the problem at hand. Medical Staff members may also be appointed to serve on Quality Care Teams as directed by the Quality Care/Patient Safety Committee and as relevant to their areas of expertise. Results and findings of Medical Staff Performance Improvement activities will be reported to the Quality Care/Patient Safety Committee, Medical Executive Committee, and the Board of Trustees.

G. Department Directors

The Department Director of each ancillary/nursing service area is responsible for all Performance Improvement and Patient Safety activities as they relate to their specific areas. The 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. The Directors are responsible for evaluating the effectiveness of care delivered in their departments and the clinical performance of their staff. Although it is recognized that process issues or deficiencies account for most variances in performance, when performance improvement 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. Significant findings of Performance Improvement or patient safety activities will be reported through the appropriate channels.

IV.   METHODOLOGY

The Model for Improvement, developed by the Associates in Process Improvement and endorsed by the Institute for Healthcare Improvement, is the methodology used for Performance Improvement projects. This model is used to promote acceleration in improvement. The model has 2 parts, 3 fundamental questions and the Plan- Do- Check Act (PDCA) cycle. Using appropriate tools and techniques data are systematically aggregated and analyzed on an ongoing basis. Statistical tools used are displayed in **attachment 2.**

Fundamental Questions:
1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in an improvement?

PDCA
➤ Plan specific process changes. Define the problem, gather data, analyze data.
➤ Do implement the plan
➤ Check results. Measure to determine the effectiveness of the plan.
➤ Act to sustain improvement and continue to improve or abandon change and start cycle again.

Root Cause Analysis is the primary methodology utilized for analysis of significant unanticipated outcomes. This process is detailed in this Plan under "Mechanism for identification and management of Sentinel Events and Near Misses".

Failure Mode and Effect Analysis (FMEA) is the primary methodology utilized for analysis of the Patient Safety Priority. This methodology will be driven by appropriate tools and techniques and utilize a team approach.
It will include at a minimum:
▪ Description of the chosen process through use of a flow chart.
▪ Potential failure modes – identification of any steps in the process where there is or may be undesirable variation
▪ Effect and criticality assessment for each failure mode
▪ Prioritizing the potential process breakdowns or failures
▪ For critical effects – a thorough analysis to determine why the variation leading to that effect may occur
▪ Redesign of the process or underlying system to minimize the risk to patients and to proactively promote patient safety.
▪ Testing and implementing the redesigned process
▪ Monitoring the effectiveness of the redesigned process

V. DESIGNING PROCESSES AND PERFORMANCE MEASURES INTO PROCESSES

When processes, functions or services are planned or redesigned, the following will be considered and incorporated to assure they are well designed and effective:
- Needs and expectations of patients, staff and others
- Consistency with the mission, vision, and strategic plans
- Consistency with sound business practices
- Results of performance improvement activities, when available
- Information about potential risks to patients, when available
- Current knowledge, when available and relevant (practice guidelines, successful practices, information from relevant literature and clinical standards)
- Information about sentinel events, when available and relevant
- Testing and analysis to determine whether the proposed design or redesign is an improvement
- Collaboration with staff and appropriate stakeholders

Performance expectations that will become the benchmarks to be used for comparison to our actual performance will be identified and measured.   To define our performance measures, the following criteria will be used:
- The measure can identify the events it was intended to identify.
- The measure has a documented numerator and has a denominator statement or description of the population to which the measure is applicable.
- The measure has defined data elements and allowable values.
- The measure can detect changes in performance over time.
- The measure allows for comparisons over time within the hospital or between the hospital and other hospitals.
- The data intended for collection are available.
- Results can be reported in a way that is useful to the hospital.

VI. DATA COLLECTION

Data about our current performance will be collected to provide information to allow the hospital to:
- Make informed judgments about the stability of our existing processes.
- Identify opportunities for improving processes and promoting patient safety.
- Identify changes that lead to improvement or sustain improvement.
- Identify the need to redesign processes.
- Decide if improvements or redesign of processes meet objectives.
- Identify areas for further study.

Hospital leaders set priorities for data collection and for which processes to monitor by considering, in relation to our mission, customer concerns, and available resources, the important care, services and functions the hospital provides. Priorities are set with consideration to scope of services, population served and high volume, high-risk or problem-prone processes and the associated incidence, prevalence and severity of problems. The priority setting is sensitive to emerging needs within the environment of care and the community, significant unanticipated outcomes, patient and staff perceptions, and changing regulatory requirements. Over time, data collection will include measures that relate to each of the important functions described in the Joint Commission *Comprehensive Accreditation Manual for Hospitals.*

The number and scope of distinct improvement projects conducted annually will be proportional to the scope and complexity of the hospital's services and operations. The hospital will consider participation in cooperative projects with the Medicare Quality Improvement Organization.
Once the leaders determine the scope and focus of monitoring and data collection, they decide:
- How to organize the activities into a systematic approach.
- The frequency and detail of data collection.

Southern Hills Hospital and Medical Center Performance Improvement Plan

- The relevant dimensions of performance, i.e., efficacy, appropriateness, availability, continuity, safety, efficiency, timeliness, effectiveness, and the respect and caring in which services are provided, to be monitored.
- How the data will be collected as part of daily work processes.

This information will be used to establish continuous performance measures that will be used to evaluate the stability of processes, the predictability of outcomes and assess the risks to patient safety. Results will be used by the leaders to determine if more focused data collection and analysis is needed. The following are important processes that will be measured on a continuous basis:

- Operative and other invasive procedures.
- Medication management including medication reconciliation and medication safety.
- Blood and blood product use.
- Utilization Management: appropriateness of admission, continued hospitalization, discharge planning and readmissions.
- Risk management activities
- Mortalities
- Autopsy results, when performed.
- Organ procurement effectiveness.
- Quality control activities in the following areas: Clinical Laboratory, Diagnostic Radiology, Dietetic Services, Nuclear Medicine, Radiation Oncology, Pulmonary Medicine, Infection Control, equipment for use in administering medicine, Pharmaceutical equipment used to prepare medications.
- Staff opinions and needs regarding improvement opportunities, willingness to report unanticipated adverse events, perceptions of risks to patients and suggestions for improving patient safety
- Completeness, accuracy, and timely completion of medical records.
- Infection control, prevention, surveillance and reporting
- Patient perception of care, treatment and services to include; specific needs and expectations, how well the organization meets these needs and expectations; how the organization can improve patient safety and the effectiveness of pain management.
- Performance Standards for each of the seven Management of the Environment of Care sections.
- Use of restraints.
- Use of seclusion
- Critical Values
- Patient Complaints and Grievances
- Review of Transfer Audits
- CS Pathology Review
- Core Measures Reviews
- HCAHPS Review
- Sentinel Events, Healthcare Acquired Conditions, Serious but Preventable Events
- Results of Root Cause Analysis
- Results of FMEAs
- Areas targeted by the hospital leaders as priorities
- Research activities when applicable
- Clinical Events by Department/Teams - Specific indicators that have been identified by the Departments or teams.
- Outcomes of Resuscitation
- Processes that impact patient safety
- Occurrence of unanticipated adverse events defined as an unintended act, either of omission or commission, or an act that does not achieve its intended outcome
- Staffing effectiveness
- Compliance with National Patient Safety Goals
- Compliance with physician documentation of critical values.
- Handoff communication
- Improve recognition and response to change in condition.

Data is also collected as indicated for participation in the following external databases:

HealthInsight - The CMS contracted Quality Improvement Organization has developed Healthcare Quality Improvement Initiatives that examine patterns of practice. Areas for study are suggested by practitioners in the community, university, hospital settings, nationally recognized patient safety and quality improvement organizations and CMS. Studies enable hospitals and physicians to compare their performance with what may be optimal levels of practice.

Hospital Compare Website - Database that includes comparative data for all the CMS Quality Measures included in the National Quality Alliance (NQA). Includes specific measures supported by CMS, JCAHO, the National Quality Forum and other healthcare quality organizations. Measures include evidenced based care indicators for Acute MI, Heart Failure, Pneumonia and Surgical Care Improvement Project. Additional indicators will forthcoming in this project.

QNet Exchange – CMS supported application for accessing and uploading data for numerous projects. Implemented in 2004, this database is expanding rapidly. Currently supports NQA measures, and upload of the new ICD data collection requirements for CMS.

CHOIS Reports - Comprehensive Health Outcomes Information System is designed to identify opportunities for improvement, identify best practices, and manage resources appropriately, effectively, and efficiently. Clinical Outcome Summary Reports are distributed on a quarterly basis. The data captured in this report reflects numerous clinical indicators. These indicators were developed through physician focus groups. The data is risk and severity adjusted using CMS's Refined DRG's and ECRI, a risk index used to adjust complication rates, RAMI, Risk Adjusted Mortality Index and RASPEC, the risk adjustment specialty algorithm as appropriate. Each hospital is provided with actual and risk adjusted mortality and complication rates. Rates are compared to the company overall and national statistics provided on a semi-annual basis by Solucient. Patient and physician level details are provided to facilitate a detailed analysis of the cases reflected in the data.

ORYX /Joint Commission National Hospital Quality Measures – This database is the Joint Commission initiative to integrate performance measures into the accreditation process. It involves collection of service, process and outcome indicators related to specific patient populations. Measures selected include Acute Myocardial Infarction, Heart Failure, Community Acquired Pneumonia, and Surgical Care Improvement Project. Data for this initiative is collected through the COMET (Comprehensive Outcomes Measurement Evaluation and Transmission) database. The information is collected at the facility level and transmitted directly to the JCAHO from HCA, as the chosen vendor for this project.

Nevada Central Cancer Registry is a database that collects data on patients admitted to this hospital for the purpose of diagnosing and/or treating certain cancer. The data is abstracted by state Cancer Registrars and submitted to state, regional and national databases where incidence and survival rates can be compared.

State of Nevada Sentinel Event Registry - Implemented in 2004 for mandatory reporting of Sentinel Events to the state. Submission is on an as appropriate basis. To date no reports/trends etc. have been returned to the facilities submitting.

State of Nevada Trauma Registry – Quarterly submission to state regarding all cases meeting state defined trauma criteria.

Perinatal Services Risk Modification Program is an HCA Corporate Quality Initiative. This is a national database created to help health care providers manage the risk associated with the delivery of maternal and infant care.

Leapfrog- the Leapfrog Hospital Survey is the public reporting initiative launched in 2001 by the Leapfrog Group. The Leapfrog Group is a voluntary program aimed at mobilizing employer

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purchasing power to alert American's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. Among other initiatives, Leapfrog encourages transparency and easy access to health care information as well as rewards for hospitals that have a proven record of high quality care. The Leapfrog Group Survey assesses hospital performance based on four quality and safety practices that are proven to reduce preventable medical mistakes and are endorsed by the National Quality Forum.

Jointcommission.org is a website used to access data regarding core measure data, mortality rates, Patient Satisfaction rates, Priority Focus Areas as well as comparison groups, and Clinical Service Group data.

COMET is the system used to identify hospital Core Measure Patients. Once identified, the Quality Management Department will abstract these charts, and then COMET can be used to report outcomes of this abstraction.

Meditech Quality Management Module – is the primary source for internal tracking of quality indicators and performance improvement data.

The Cath Source Reports system is utilized to collect and extract data and reports regarding Cardiology outcome and process measures*.*

Knowledge based information services available through Internet access and the Atlas Intranet are used to search for current literature on specific topics to determine if our level of performance is within standards.

Departmental logs are created as deemed appropriate by each department.

Notification Reports

Patient Records

HCA Employee Survey – External survey that solicits employee feedback on a variety of topics including Patient Safety. Employees are given the opportunity to give comments during the survey.

HCAHPS Survey- External survey that solicits patient feedback regarding the care received while hospitalized, as well as nursing and physician information and hospital cleanliness.

PI/ Patient Reporting – Meditech Notification system is utilized to report any issues that may be identified. Can be entered as non-patient if system type issue, employee view or opinion is to be expressed

Quarterly Patient Safety Survey - Rounds made to query staff on Patient Safety issues and opinions solicited at that time.

Executive Walk Arounds are done to allow staff to voice their views on a variety of issues including Performance Improvement and Patient Safety

Patient Safety Activities are conducted to educate staff and allow staff to share ideas or suggestions of patient safety improvements house-wide

VII. AGGREGATION AND ANALYSIS

Aggregated data are analyzed in order to make judgments about:

- whether design specifications for processes were met,
- the level of performance and stability of important existing processes,
- opportunities for improvement,
- actions to improve the performance of processes, and
- whether changes in the processes resulted in improvement.
- opportunities to reduce the risk of sentinel events,
- opportunities to improve patient safety.

The frequency at which data are aggregated is determined by the processes being measured and the hospital priorities for improvement.

Appropriate statistical techniques are used to analyze and display data. See diagram 2, which identifies the statistical tools and techniques used in the IHI Model for Improvement method.

Methods used to evaluate our performance and determine if there is excessive variability or unacceptable levels of performance include, as appropriate, performance compared internally over time, performance compared to performance of similar processes in other hospitals and performance compared to external sources of information.
When data analysis leads to the detection or suspicion of undesirable patterns/trends in performance or an unexpected, serious, adverse, patient related event, an analysis will be conducted.

Specifically, analysis will occur for the following:
- Important single events, levels of performance, patterns, or trends that vary significantly and undesirably from those expected present significant potential risk to patient safety.
- Performance that varies significantly and undesirably from that of other hospitals.
- Performance that varies significantly and undesirably from recognized standards.
- Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnosis, including those identified during the pathologic review of specimens removed during procedures.
- Confirmed transfusion reactions.
- Serious adverse drug reactions and significant medication errors, i.e., unintended, undesirable and unexpected effects of prescribed medications or medication errors that require initial or prolonged hospitalization, result in disability, result in cognitive deterioration or impairment, are life threatening, or result in death or in congenital anomalies.
- Adverse events or patterns of adverse events during moderate or deep sedation and anesthesia use.
- Those topics chosen by the leaders as performance improvement priorities.
- Undesirable variation occurs which changes priorities.
- Hazardous conditions defined as any set of circumstances (exclusive of the disease or condition for which the patient is being treated) that significantly increases the likelihood of a serious adverse outcome.
- Staffing effectiveness issues.
- A minimum of one high-risk process that is identified for proactive risk assessment. The choice will be based in part on information published periodically by the Joint Commission about the most frequent sentinel events and risks.

Mechanism for identification and management of unexpected, serious, adverse, patient related events. (Sentinel Events and Near Misses)
A Sentinel Event is defined as an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Also included in the definition of a Sentinel Event are patient suicide, restraint deaths, elopement death and any of the following, even if the outcome is not death or major permanent loss of function:

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- Abduction of any patient receiving care, treatment or service
- Patient suicide
- Any patient death related to use of restraints
- Elopement Death
- Infant abduction or discharge to the wrong family
- Any intrapartum (related to the birth process) maternal death
- Any Perinatal death unrelated to a congenital condition in an infant having a birth weight greater than
- Neonatal serum bilirubin >30 mg/deciliter
- Any patient death, paralysis, coma or other major permanent loss of function associated with a hospital acquired infection
- Unintended retention of a foreign object in an individual after surgery or other procedure
- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of wrong region of >25% above the planned dose
- Assault/Rape/Homicide
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery on the wrong patient or body part
- Serious medication errors

Near Miss is 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. Such a near miss falls within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by the Joint Commission under its Sentinel Event Policy.

Of primary importance after a serious event is the safety and clinical care needs of the patient following a Sentinel Event or serious occurrence:
- Ensure the safety of the patient and provide appropriate care
- Notify the physician and department Director or in their absence House Supervisor
- Preserve any relevant or potentially relevant physical evidence, equipment or documentation that the investigation and analysis of the incident (example: medication packaging, infusion pump, tubing etc.
- Document the facts of the incident, actions taken, patient response, appropriate notification of the physician in the patient record via Meditech
- Complete an occurrence report in the Meditech system and provide phone notification to the quality management department.

Potential sentinel and near miss events will be reported to the Quality/Risk Management Department either by phone or in writing. Any equipment, tubing, wrappers, labels, or other items that may be associated with the event should be taken out of service, appropriately tagged, and secured immediately. The Quality/Risk Management Department in collaboration with the appropriate Department directors will conduct an initial investigation into the event. Findings of the investigation will be presented to the CEO. It will be the responsibility of the CEO, in collaboration with the Chairman of the Quality Care/Patient Safety Committee, to determine if the event falls within the scope of a sentinel event or a near miss and to make a decision regarding the self-reporting of the event to the appropriate external agencies in accordance with law and regulation.

All sentinel events will be reported to the Patient Safety Officer within 24 hours of the occurrence. The Patient Safety Officer shall, within 13 days after receiving notification will report the date, time and a brief description of the sentinel event to the State of Nevada Health Division. (NRS 439.835)

In the absence of notification, the Patient Safety Officer will, within 14 days of discovery, report the date, time and a brief description of the sentinel event to the State of Nevada health division, Chairman and Administration.

Notification to patients regarding Sentinel Events will occur within 7 days after discovery in accordance with the hospital's "Patient Notification of Unanticipated Outcome" policy.

The leaders will require a thorough and credible Root Cause analysis to ensure the causes that underlie the event are understood and to make changes to our systems and processes to reduce the probability of such an event in the future, therefore promoting patient safety.

For the Root Cause analysis to be acceptable it will:
- Focus primarily on systems and processes, not individual performance.
- Progress from special causes in clinical processes to common causes in organizational processes.
- Repeatedly asks "why" to assess underlying systems and processes that can be altered to reduce the likelihood of human error.
- Identify changes that should be made in systems and processes, either through redesign or development of new systems or processes that would reduce the likelihood of such events occurring in the future.

For the Root Cause analysis to be thorough it will include:
- A determination of the human and other factors most directly associated with the event and an analysis of the underlying systems and processes related to its occurrence.
- An analysis of the underlying systems and processes through a series of "why" questions to determine where redesign may reduce risk.
- The identification of risk points, their potential contributions to this type of event.
- The identification of the potential improvement processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, that no such improvement opportunities exist.

For the Root Cause analysis to be credible it will:
- Include participation by the leadership of the organization and by the individuals most closely involved in the processes and systems under review.
- Not contradict itself or leave obvious questions unanswered.
- Consider of any relevant literature.

A risk reduction strategy and action plan will be created, documented and implemented. This plan will include
- Who is responsible for implementation.
- A timeline for implementation.
- How effectiveness will be measured.

The Quality Care/Patient Safety Committee will assume the oversight for the event by reviewing and approving activities and actions developed by the interdisciplinary team. The Quality Care/Patient Safety Committee will assure appropriate methodologies are utilized, a thorough, credible analysis is conducted and corrective action plans are complete and appropriate, and that post implementation monitoring reflects effective process improvement. The documentation of the analysis must be completed within 45 days of the date of the event or becoming aware of the event. The corrective action plan must include measurement of outcome indicators, process improvements, and measurement of effectiveness. The Director of Quality/Risk Management will be responsible for oversight and follow-up of this process.

Physician specific issues identified in the interdisciplinary peer review will be referred to the Chief of the appropriate Medical Staff Department.

To reduce the risk of potential Sentinel Events, Near Misses, and to identify patient safety risk factors, the organization will review available information about these types of events known to occur with significant frequency in other hospitals which provide similar care and services. This review will include, but is not limited to Sentinel Event Alerts, Perspectives on Patient Safety, Institute for Safe Medication Practices (ISMP) Alerts and other current literature. Appropriate staff will be involved in the review to assure that care and services can be designed or redesigned, if necessary, to prevent similar events from occurring at Southern Hills Hospital and Medical Center.

Effectiveness

The leaders will measure and assess the effectiveness of their contributions to improving performance and improving patient safety. Methods used include but are not limited to:

- Self-evaluation using pre-established, objective criteria.
- Assessment of the results of performance improvement and proactive patient safety indicators.

Education

The orientation process will include information about performance improvement patient safety. The information will reflect a patient centered approach and focus on:

- Basic approaches to performance improvement and proactive patient safety
- Communication and cooperation among staff and departments
- The need to report and methods of reporting unanticipated adverse events
- Promotion of a safe work environment
- Reporting mechanisms that ensure a non-punitive approach which includes but is not limited to the employees ability to report patient safety and quality of care concerns directly to the Joint Commission
- Leadership commitment to PI and Proactive Patient Safety
- Scope of the Proactive Patient Safety Program
- System for internal and external reporting of information related to unanticipated adverse events
- Sentinel Event and Root Cause Analysis procedures
- Mechanisms available to support staff involved in an event
- PI and Proactive Safety Priorities

Based on performance improvement and proactive patient safety findings, ongoing education will be provided as appropriate.

BOARD OF TRUSTEES

MEDICAL EXECUTIVE COMMITTEE

CREDENTIALS COMMITTEE

QUALITY CARE/PATIENT SAFETY COMMITTEE
Functional Performance Measures
Quality Control
Quality Care Teams
Outcome Studies
Contracted Services
Customer Satisfaction

Functions	Standing Committees	PI Teams/Committees
• Patient Rights • Patient Safety • Provisions of Patient Care • Medication Management • Information Management • Risk Management • Medical Staff Indicators • Human Resources Management • Medication Management • Emergency Management	• Infection Control • Utilization Review/Case Management • Perinatal Taskforce • Pharmacy	• Bioethics • Radiation Safety • Stroke • Sepsis • Chest Pain/CV • Patient Falls • NICHE

Improvement Methods

Fundamental Question	Description	Tools
1. What are we trying to accomplish?	Setting Aims: Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.	Executive Walk Around Data Collection Tools Brainstorming
2. How will we know that a change is an improvement?	Establishing Measures: Teams use quantitative measures to determine if a specific change actually leads to an improvement.	Brainstorming Cause and Effect Diagram Flow Chart
3. What changes can we make that will result in improvement?	Selecting Changes: All improvement requires making changes, but not all changes result in improvement. Must identify the changes that are most likely to result in improvement.	Cause and Effect Diagram Flow Chart Run Chart Pareto Chart Control Chart Brainstorming
Act | Plan Check | Do	Testing Changes: The Plan-Do-Check-Act (PDCA) cycle is shorthand for testing a change in the real work setting- by planning it, trying it observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.	Flow Chart Run Chart Pareto Chart Control Chart
	Implementing Changes: After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale.	Brainstorming Cause and Effect Diagram Flow Chart Pareto Chart Run Chart
	Spreading Changes: After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization.	Brainstorming

Division of Public and Behavioral Health

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

Inpatient Patient Safety Plan

2 0 1 6

SNAMHS

Southern
Nevada
Adult
Mental
Health
Services
Improving Quality of Life

PURPOSE:

The purpose of this document is to overview the 2016 Inpatient Patient Safety Plan for Southern Nevada Adult Mental Health Services. The plan facilitates education, communication, consistency and effectiveness of the Patient Safety Program agency-wide.

This patient safety plan ensures that Southern Nevada Adult Mental Health Services (SNAMHS) implements and maintains a patient safety program in accordance with the Joint Commission standards, CMS Standards and guidelines from state and federal licensing and regulatory agencies.

RESPONSIBILITY:

It is the responsibility **of all employees** of Southern Nevada Adult Mental Health Services to be familiar with the contents of this plan and adhere to the procedure outlined within.

DISTRIBUTION:

This Patient Safety Plan shall be distributed agency-wide in Southern Nevada Adult Mental Health Services, to the Division of Public and Behavioral Health Administration, and the Local Governing Body.

INTRODUCTION:

The Patient Safety Plan supports and promotes the mission, vision and values of Southern Nevada Adult Mental Health Services through **the practice of developing and implementing a culture of safety among its clients, staff, and visitors.**

The Southern Nevada Adult Mental Health Services (SNAMHS) 2016 Safety Plan is implemented through the continuous integration and coordination of the patient safety activities of medical staff, inpatient and outpatient clinical departments, community service and support service departments that have the responsibility for various aspects of patient and staff safety.

Each employee of the organization performs a dedicated and critical role in ensuring patient and employee safety. All employees are responsible for monitoring the environment and patient care systems for actual and potential safety hazards and are responsible for bringing those concerns to the Patient Safety Officer or the Safety Committee. The agency-wide patient safety program is designed to reduce errors and hazardous conditions 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 and hazardous conditions; ongoing proactive reductions in medical/health care errors; and integration of patient safety priorities in the design and redesign of all relevant agency processes, functions and services.

Rev. 2/2016

Southern Nevada Adult Mental Health's integrated patient safety program is implemented through the Quality Assurance and Performance Improvement program. The Statewide Quality Assurance and Performance Improvement Manager appoints the Patient Safety Officer, provides oversight and ensures alignment of patient safety activities and initiatives with overall agency performance and improvement initiatives.

The Patient Safety Officer has the authority to investigate and intervene on any clinical or non-clinical activity, which poses a potential or actual negative outcome to a patient's wellbeing. The Patient Safety Officer involves the Director of Quality Assurance and Performance Improvement, the Southern Nevada Adult Mental Health Services Administrator, Department or Program Directors and the Patient Safety Committee in the initiation and or review of corrective action measures as is appropriate in each situation.

The Patient Safety Committee membership includes a member of executive leadership, the Patient Safety Officer, a member of medical staff, a member of nursing leadership, a member of pharmacy staff, a member of social services, the Infection Control Officer, a clinical representative, a member of psychiatry, and other members as needed on an ad hoc basis. The members designated above may appoint a designee in their absence.

The Administrator, Governing Body, Medical Executive Committee, Quality Assurance and Performance Improvement Team, Patient Safety Committee and Environment of Care Committee are committed to patient safety, assuring an environment that encourages continuous hazard reduction, error identification, remediation, non-punitive reporting and prevention through education, system redesign or process improvement for any adverse events or conditions. Proactive assessment of high-risk activities and hazardous conditions are identified through aggregate data collection and utilization review. In addition, available information about National Patient Safety Goals (NPSG) for Behavioral Health Organizations and Hospitals, as well as, sentinel events known to occur in health care organizations that provide similar care and services are built into the system.

The Patient Safety Plan presents the opportunity through proper and effective orientation and training that emphasizes clinical and non-clinical aspects of patient safety, an interdisciplinary approach to patient care, improvement of patient safety and the requirement and mechanism to report errors, incidents and accidents, and environmental safety concerns.

Emphasis also is placed on patient safety in areas such as patient's rights, patient family education, continuity of care and a process for managing potential or actual performance deficiencies. Full disclosure of sentinel events, serious errors, reportable events and any unanticipated outcome are made to patients/families through the provider as appropriate. Accrediting and licensing bodies are notified as appropriate.

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SCOPE:

Risk Identification and Risk Factor Mitigation

The Patient Safety Officer receives safety event information collected by the Quality Assurance and Performance Improvement Team. In addition, all SNAMHS employees are empowered and encouraged to report information on potential and actual safety issues or events. The information includes actual or potential occurrences involving inpatients, outpatients, employees and visitors. Information is provided from all the employees and medical staff through completion of incident reports, client complaints and grievances and verbal communication.

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

Types of errors included in data analysis include:

Near Misses: Any process variation which did not affect the outcome due to a screening by chance but a recurrence carries a significant chance of a serious adverse outcome. Some may call it a potential for error.

Occurrence: An event that is not consistent with routine patient care or hospital procedure which either did not or could have resulted in injury, loss to a patient or visitor or which may give rise to a claim against the Hospital, an employee of the hospital, or a member of the hospital medical staff.

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.

Hazardous Condition: Any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function.

Any caregiving process with a **misuse**, **underuse** or **overuse** of care will also be a subject for review and further analysis.

Investigation, Analysis, Coordination and Reporting

A broad range of data analysis will be reported to and reviewed by the Patient Safety Committee monthly. The results of investigations and analytical reviews shall, be forwarded by the Patient Safety Officer to the appropriate entities for further, in-depth evaluation, review and responses. Responses shall include any corrective action taken or plan for corrective action. The Patient Safety Committee serves as a clearinghouse for data and information that affects patient safety.

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Any incident, process, event and condition may be subject to investigation through the Root Cause Analysis (RCA) method as determined by the RCA Committee appointed by the Medical Director. Intensive assessment may be initiated when undesirable patterns or trends are identified or a serious or sentinel event occurs. The   Patient Safety Officer or designee will report the results of the RCA and recommended Plan of Correction to the Patient Safety Committee at the next meeting following the conclusion of the RCA.

In accordance with the Joint Commission's Accreditation Participation Requirements

- APR.09.02.01 this plan mandates that:

- SNAMHS educates its staff that any employee who has concerns about the safety or quality of care provided in the hospital may report these concerns to The Joint Commission.
- SNAMHS also informs the staff that no disciplinary or punitive action will be taken when an employee reports safety or quality of care concerns to The Joint Commission.
- SNAMHS takes no disciplinary or punitive action against employees when they do report safety or quality of care concerns to The Joint Commission.

Patient Safety Goals in SNAMHS:

SNAMHS follows the guidelines of National Patient Safety Goals, the Nevada State Registry and the sentinel event advisory board of The Joint Commission. Patient Safety Indicators for National Patient Safety Goals are observed effectively and continuously in all patient care areas of SNAMHS. All operational areas of SNAMHS facilities are monitored for patient safety compliances by its staff and reported to the Patient Safety Committee monthly.

Sentinel Event:

The 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*

An event is also considered sentinel if it is one of the following:

- Suicide of any patient receiving care, treatment and services in a staffed around-the clock care setting or within 72 hours of discharge.
- Death of any patient receiving care, treatment and services in the inpatient or within 72 hours of discharge or a documented visit in an outpatient clinic;
- Any injury or death related to seclusion and restraint;
- Abduction of any patient receiving care, treatment, and services;

- Elopement of any patient from the inpatient unit which results in serious harm to self or others or death.
- Medication Error or adverse drug event resulting in serious harm or death.

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.

The patient safety plan includes performance and measures of success through an analysis of Patient Safety Indicators based on multiple patient safety programs, such as; National Patient Safety Goals by the Joint Commission, CMS, and internal and accident report trend analysis. Each one of these indicators is constructed based on the Joint Commission's National Patient Safety Goals Implementation Expectations for requirement of each standard.

PATIENT SAFETY INDICATORS:

Goal 1: Improve the accuracy of the identification of individuals served.

NPSG.01.01.01 Use of two patient identifiers when providing care, treatment or services.

Elements:
1. Use at least two identifiers when administering medications or collecting specimens for clinical testing (the room number or physical location is not used as an identifier); and
2. Label containers for specimen collection in front of the client..

Goal 2: Improve staff communication among caregivers and report critical results of tests and diagnostic procedures on a timely basis.

NPSG.02.03.01 Critical results of tests and diagnostic procedures that fall significantly outside of normal range may indicate a life threatening situation.

Elements:
1. Develop written procedures for managing critical results of tests and diagnostic procedures that address the following:
   a. The definition of critical results of tests and diagnostic procedures
   b. By whom and to whom critical results of tests and procedures are reported
   c. The acceptable length of time between availability and reporting of critical results.
2. Implement procedures for managing the critical results of tests and diagnostic procedures; and
3. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.

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Goal 3: Improve the safety of using medications.

NPSG.03.04.01 Label all medications, medication containers, and other solutions. Labeling all medications, medication containers and other solutions is a risk reduction activity consistent with safe medication management.

Elements:

1. Label medications and solutions that are not immediately administered. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to the patient and administers to that patient without any break in the process;
2. Medication labels will include the medication name, strength, quantity and expiration date;
3. Verify all medication labels verbally and visually. Verification is done by two individuals whenever the person preparing the medication is not the person administering it; and
4. Immediately return medication or solution found unlabeled to the pharmacy.

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 thrombus 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.

Elements:

1. Use approved protocols for anticoagulation therapy;
2. Before starting a patient on warfarin, assess the patient's baseline anticoagulation status;
3. Manage potential food and drug interactions for patients receiving warfarin;
4. Maintain a written policy to address use of anticoagulants and assessment of baseline and ongoing laboratory tests that are required for the use of anticoagulants; and
5. Provide education to prescribers, staff, patients and families which includes;
   a. Importance of follow up monitoring,
   b. Compliance,
   c. Drug-food interactions,
   d. The potential for adverse drug reactions and interactions.

NPSG.03.06.01 Maintain and communicate accurate patient medication information.
   Elements:
   1. Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting;
   2. Define the types of medication information to be collected in non-24 hour settings and different patient circumstances;
   3. Compare the medication information the patient brought to the hospital with the medications ordered for the patient in order to identify discrepancies;
   4. Provide the patient (or family) with written information on the patient's medications on discharge from the hospital or at the end of an outpatient encounter; and
   5. Explain the importance of managing medication information to the patient when he/she is discharged from the hospital or at the end of an outpatient encounter.

Goal 4: Decrease medication errors.
MM.04.01.01 Medication orders are clear and concise
   Elements
   1. The registered nurse must "Read Back" all telephone orders to the physician/practitioner to ensure accuracy and document "Read Back".
   2. Illegible and/or questions or concerns regarding an order the RN must contact the physician/practitioner for clarification prior to transcribing the order in the MAR.
   3. The transcribing RN must review the chart order and the MAR with a second nurse for review for accuracy of the transcribed order to include but not limited to Client Name, Medication, Dosage, Route, and Time.
   4. The verifying nurse co-signs the order by noting verified with name, date and time as well as initialing the corresponding box on the MAR documenting that the review of the MAR was completed.
   5. Upon administration of the medications the nurse will review the chart with the MAR of the patient receiving medication, check for allergies, the name of the medication, dose, route, time, then check the medication and dosage of the medication with the MAR and check the expiration date of the medication.
   6. Immediately document the medication given on the MAR.

Goal 5: Reduce the risk of health-care associated infections.
NPSG.07.01.01 Comply with the Centers for Disease Control (CDC) or World Health Organization (WHO) guidelines for hand hygiene.
   Elements:
   1. Implement a program that complies with CDC and/or WHO hand hygiene guidelines;

2. Establish goals for improving compliance with hand hygiene; and
3. Improve hand hygiene compliance based on established goals.

NPSG.07.03.01 Implement evidence-based practices to prevent health-care associated infections due to multidrug resistant organisms (MDRO) in acute care hospitals. This requirement applies to but is not limited to MRSA (methicillin-resistant staphylococcus), CDI (clostridium difficile), VRE (vancomycin-resistant enterococcus) and multidrug resistant gram negative bacteria.
  Elements:
  1. Conduct periodic risk assessments for multidrug resistant organism acquisition and transmission;
  2. Based on risk assessment, educate staff and licensed independent practitioners about health-care associated infections, multidrug resistant organisms and prevention strategies at hire and annually thereafter;
  3. Educate patients and their families (as needed) who are infected or colonized with a multidrug-resistant organism about health-care associated prevention strategies;
  4. Implement a surveillance program for multidrug-resistant organisms based on risk assessment;
  5. Measure and monitor multidrug-resistant organism prevention strategies and outcomes including:
     a. multidrug-resistant organism infection rates;
     b. compliance with evidence-based guidelines or best practices;
     c. Evaluation of the education program for staff and licensed independent contractors.
  6. Provide multidrug-resistant organism process and outcome data to key stakeholders, including leadership, licensed independent practitioners, nursing staff and other clinicians.
  7. Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms.
  8. When indicated by risk-assessment implement a laboratory based alert system that identifies new patients with multidrug-resistant organisms.
  9. When indicated by risk assessment, implement an alert system that identified readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.

Goal 6: The hospital identifies safety risks inherent in the patient population
NPSG.15.01.01 Identify patients at risk for suicide
Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.
  Elements:
  1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease risk for suicide;

2. Address the patient's immediate safety needs and the most appropriate setting for treatment; and
3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information such as the Suicide Prevention Lifeline to the patient and his or her family.

Goal 7: The hospital assesses and manages the patient's risk for falls.
PC.01.02.08 Identify patients at risk for falls
Elements:
1. Assess all patients for risk of fall on admission;
2. During transfer to a different unit;
3. Any change in the client's condition;
4. Any change in the client's medication (s) that increases the client's risk for falls such as Benzodiazepines, psychotropic, anti-convulsant, anti-hypertensive, diuretic, sleeping medications, etc.;
5. Any change in the client's functional ability/status;
6. Following a fall;
7. Weekly for clients identified as a fall risk;
8. Other reasons as necessary; and
9. Implement interventions to reduce falls based on patient's assessed risk.

Patient Safety Educational Enhancement Activities- Translating Research into Practices

The agency orientation program emphasizes error reduction and specific job-related aspects of patient safety. Ongoing in-service and other educational programs emphasize specific job-related aspects of patient safety. As appropriate, training incorporates methods of team training to foster interdisciplinary, collaborative approach to the delivery of patient care and reinforces the need and way to report errors.

The safety of the health care delivery system is enhanced by the involvement of the patient as appropriate to his/her condition as a partner in the health care process. The comment and patient satisfaction survey encourages the patients' participation and suggestions for changes.

Organization, Authority and Responsibility

The authority to implement the Patient Safety Plan rests with Governing Body, Medical Executive Committee, Patient Safety Committee, Environment of Care Committee and Departmental Leadership. This plan is evaluated yearly. The Patient Safety Officer (PSO) enforces the plan at a multidisciplinary level and reports to the Agency Administrator and the Director of Quality Assurance and Performance Improvement who provides the strategic oversight of the Patient Safety Program. It will coordinate the risk mitigating efforts on environment of care issues.

The Patient Safety Committee is formed to improve patient outcomes and reduce morbidity and mortality within SNAMHS. The record keeping, data and knowledge collected by this Patient Safety Committee shall only be used for those purposes, consistent with the purpose set forth in the Nevada State Public Law (J-M)

2805. As such, the records, data and knowledge collected by this committee are intended to be confidential, privileged and not for public records and shall not be available for any legal proceedings as per the Nevada State Public Law.

DUTIES:

Patient Safety Committee

The committee provides a multidisciplinary forum for the collection of and analysis of risk to patient safety and the dissemination of information on identified risk for the purposes of improving patient care and reducing morbidity and mortality within the Hospital. It shall review reports on occurrences typically ranging from 'No Harm' frequently occurring 'Near Misses' to 'Sentinel Events' with serious adverse outcomes, claims, and identified risks, which are gathered in accordance with this plan. The Committee will promote the application of evidence-based methods and will promote the use of shared metrics in the evaluation of related patient safety activities.

Risk Reduction Committee

Risk Reduction is a subcommittee of the Patient Safety Committee and is dedicated to developing education, supporting staff and reducing assaults, seclusion and restraints through employee and patient safety and provides the Patient Safety Committee a Risk Reduction Performance Plan yearly.

Reporting Flow Map

Patient Safety Committee reports to the Director of Quality Assurance and Performance Improvement (QAPI) and the Hospital Administrator. The Patient Safety Plan will be carried out at the departmental level. Any feedback from departments will come to the Patient Safety Officer and/or Committee and will be communicated to the Director of Quality Assurance and Performance Improvement by the Patient Safety Officer.

Patient Safety Committee will meet a minimum of ten (10) times per year usually once a month. The Patient Safety Committee reports monthly to the Medical Executive Committee, the Agency Administrator and quarterly to the Local Governing Board and shares any outstanding patient safety issues. Additional meetings may be scheduled at the call of the Committee Co-Chairs.

<center>**Spring Mountain Sahara**
ORGANIZATIONAL PLAN FOR PATIENT SAFETY</center>

PURPOSE

Spring Mountain Sahara is committed to the well being and safety of patients. We acknowledge the process of health care delivery is complex and requires effective coordination within an organization to minimize the risks of adverse occurrences. We believe leaders must demonstrate the importance of patient safety through a comprehensive and non-punitive program for the prevention, detection and response to health care errors. We believe staff well trained in safety principles reduces the likelihood of errors. We believe an active partnership with the patients we serve will result in desired patient outcomes.

GOALS

The goals of the Organizational Plan for Patient Safety are:
1. Establish and maintain effective operational systems to prevent errors
2. Assure the safe delivery of care and services at Spring Mountain Sahara
3. Promote culture of patient safety priority
4. Foster non-punitive approach to error detection and response

OBJECTIVES

1. Establish priorities for Patient Safety
2. Coordinate functions, processes and systems related to patient and organizational safety within all services and departments
3. Design and redesign functions, processes and systems when an opportunity to improve patient safety exists
4. Incorporate best safety practices into organizational systems and processes
5. Provide interdisciplinary collaboration of safety in the environment of care
6. Standardize and integrate organization wide policies and procedures related to safety
7. Consider results of Performance Improvement activities in guiding safety
8. Respond to sentinel event and significant events requiring root cause analysis
9. Coordinate education and training for staff, patients and visitors related to safety
10. Utilize the Joint Commission National Patient Safety Goals as tools to improve safety and reduce errors
11. Incorporate Joint Commission Sentinel Event Alerts (applicable to Behavioral Health) into ongoing Patient Safety Process
12. Incorporate UHS Behavioral Health Division Risk Alerts into ongoing Patient Safety Process

STRUCTURE

Effective coordination and management of patient and organizational safety contributes to desired patient outcomes. The Patient Safety Council oversees the implementation of the Organization Plan for Patient Safety. The Patient Safety Council is chaired by the CEO and meets monthly, more often when necessary, to assure effective operation of functions, processes and systems related to patient and organizational safety. Patient

Safety Council members provide expert or first hand knowledge in safety aspects of clinical and administrative service delivery. Input from every department and services within the organization contributes to the well being and safety of patients. Patient Safety Council membership includes standing members who attend all Council meetings and "as needed" Council members who attend when necessary to effectively coordinate and integrate patient safety within the organization.

Patient Safety Council Standing Members:
1. CEO/Managing Director
2. Director of Performance Improvement
3. Medical Director
4. Director of Nursing
5. Risk Manager

SCOPE OF SERVICES
The Organizational Plan for Patient Safety involves all-important functions and processes that have the potential to affect the safety of services provided for inpatient and partial hospital programs.

1. Governance

   The Governing Body assumes ultimate responsibility for the safety of patients. The Governing Body approves the mission, vision and values of the organization affirming the importance of patient safety. The Governing Body delegates oversight of the Organizational Plan for Patient Safety to leaders. The Governing Body allocates sufficient financial and human resources to meet the safety needs of patients. The Governing Body assures the organization complies with applicable local, state, federal laws and regulatory requirements for patient safety. The Governing Body establishes the organizational structure for patient care responsibility. The Governing Body stays informed about adverse occurrences, Performance Improvement activities and pro-active risk reduction strategies.

2. Leadership

   Leaders implement the Organizational Plan for Patient Safety. Leaders foster a culture that promotes patient safety through a non-punitive approach to the detection and response to health care errors. Leaders approve important policies related to patient and organization safety. Leaders provide direction in carrying out the mission, vision and value of patient safety within the organization. Leaders assess the changing needs of the organization in order to maintain the highest level of patient safety. Leaders assure interdisciplinary coordination of patient and organizational safety. Leaders approve contracts for external services with reliable and credible vendors. Leaders identify sentinel events and significant events requiring root cause analysis and assure the timely and proper response to adverse events. Leaders are accountable for the safety of patients and the safe operation of the facility.

3. Management

Managers are responsible for the safe delivery of care and services within a specific branch of administrative or clinical operation. Managers are responsible for attaining and maintaining safety expertise within their scope of service delivery. Managers define safety aspects within their services or department and monitor the outcomes of performance for effects. Managers provide job specific safety training and assure department operations are integrated and coordinated within the organization.

4.   Patient Rights, Responsibilities and Ethics
Patients have the right to expect safe care and services. Patients have the right to be informed of benefits and risks associated with proposed care. Patients have the right to be informed about outcomes of care including undesired and unexpected occurrences. Patients have the right to be informed about alternatives and possible results of refused care. Patients have the responsibility to participate in treatment as much as possible, to follow instructions, rules and regulations. Patients have the responsibility to provide accurate and reliable information, to report changes and to ask questions especially when care plans are not understood. Patients have the responsibility to respect the needs of others. Patients can expect that the facility has their well being and safety in mind. Patients can expect information that is honest and accurate. Patients can expect restrictions that are limited to only those necessary for safety. Patients can expect staff conduct that is ethical and safe.

5.   Assessment of Patients
Assessment of patient safety needs is a dynamic process occurring through all points of service delivery. Assessment of patient safety includes physiological as well as psychosocial needs. The Admissions Department assesses whether the organization can meet the safety needs of patients desiring services. Professional assessment and reassessment of needs continues during the course of treatment in order to provide the proper database to make care decisions. Specialists assess the unique safety needs of adolescents as well as individuals who are victims of abuse or those requiring detoxification. Assessment of needs continues with the determination of safety requirements necessary for discharge or another level of care.

6.   Care of the Patient
Safety is always a priority in the care of the patient. Therapeutic programs are designed with safety in mind and the milieu is managed to promote the safety of patients, visitors and staff. All care provided is under the guidance of a physician in collaboration with an interdisciplinary treatment team. Individualized care plans and interventions are based on current scientific knowledge and professional practices guidelines. The safety and well being of the patient is always considered in the care planning process and patients and their families are encouraged to participate as much as possible. Treatment expectations and outcomes of care are discussed with the patient and family as desired. When outcomes differ significantly from expectations or when adverse occurrences or

errors occur, the patient and family, as desired are informed including the consequences and how the course of care will be affected.

Direct observation is a primary method to determine the effects of care provided. Close observation or special precautions may be employed when necessary to assure safety of the patient. Assistance is provided when necessary to restore or to maintain the well being of patients; activities of daily living. Safe methods to respond to psychiatric and medical emergencies are implemented when necessary. Pharmaceutical services carefully control the ordering, delivery, storage and dispensing of medications to prevent errors. Dietary services provide the safe nutritional needs of the patients. Diagnostic tests and evaluations required by the patient's condition that are not available within the organization are provided by credible external sources. Safety provisions are in place to transport patients to and from facilities when necessary.

7. Management of Human Resources
    A sufficient amount of qualified staff are provided to assure the safety of patients. Job descriptions define performance expectations related to patient and organization safety. General, department and job specific orientation focuses on safety matters including definitions of errors, how they are reported, managed and prevented. Initial, annual and ongoing competency determination confirms the knowledge and skills necessary to perform important safety aspects of job functions. Additional on the job training in equipment and skill application maintain the abilities of staff to provide safe quality care. Orientation, training and education in safety is revised when necessary based on emerging needs of patients, visitors and staff. When work performance affects or has the potential to affect patient safety or when sentinel events or significant events occur, Human Resources provides additional training, education and employee assistance.

8. Management of Information
    Patient information is coordinated amongst providers and users prior to service entry, during the course of care and after discharge. Electronic information and written medical records are available at points of service. The care of the patient and response to treatment is permanently maintained in clinical records. Authorization is required prior to the release or discussion of confidential patient information. Professional information sources are provided through internet and current literature subscriptions.

9. Medical Staff
    Medical Staff Bylaws and Rules and Regulations define performance expectations for licensed independent practitioners. The appointment and reappointment process assures practitioners are qualified and competent to provide privileges. Peer Review activities evaluate the safety and effectiveness of care provided. The physician's health program provides services to medical staff to assure they maintain the ability to provide safe care to patients.

10. Performance Improvement
     Performance Improvement monitors measure, assess, and improve important aspects of organization safety including high risk and problem prone services. Internal and external comparison sources provide a means to evaluate performance. When trends or patterns indicate a quality concern intense analysis is conducted to determine cause. New processes and redesigned processes are evaluated for effectiveness. Sentinel Event Alerts warrant an examination of processes to determine if the potential to reduce risk of adverse occurrences exists. Improvement strategies and best practice standards are communicated within the organization.

     The Risk Management Program identifies potential and actual risks to the organization and welfare of patients. Complaints are investigated and incidents analyzed. Processes to eliminate hazards and losses are implemented and evaluated for effectiveness. Contract provider performance is evaluated for quality and safety and claims litigation is managed.

11. Patient Education
     Education is provided to patients and families that promotes safety and enhances recovery. Individual education plans may include disease, pain and medication management, health teaching, coping strategies, proper nutrition, self-care, use of equipment and community resources. Comprehension of education learned is validated to avoid mistakes. Specialists provide academic education to children and adolescents as necessary.

12. Perception of Care
     Patients, visitors and staff are encouraged to submit comments about the care provided as well as suggestions to improve safety and services through the Patient Satisfaction Survey. Responses are reviewed and considered by leaders. Staff are commended when their ideas results in improved safety or service. Patients anonymously complete satisfaction surveys upon discharge and rate their perception of the safety of care received. In addition, patients are encouraged to submit suggestions on the satisfaction survey about ideas to improve safety conditions. Findings are analyzed and considered in process and system design.

13. Continuum of Care
     Care needs determine the level of services provided. Safety needs may trigger a change in the level of care. Processes assure prompt transition to a different level of care when necessary. Continued care and education needs identified during the course of treatment are coordinated and planned with the patient, family and alternate service provider in preparation for discharge to assure a smooth and safety transition.

14. Environment of Care
     The physical plan and patient unit designs consider the unique safety needs of the behavioral healthcare population including services to children, adolescents,

adults and older adults. Furnishings and fixtures are selected that are age appropriate and provide the safest environment of care. Internal and external space and traffic flow is planned to minimize the risks of injury to patients, visitors and staff. Safety measures are incorporated in rooms designated for the purpose of seclusion. Access to sharp and dangerous objects are controlled. The environment of care is frequently inspected for safety conditions and repairs made promptly to avoid injury. Building and construction planning complies with Life Safety Codes and considers the safety and comfort needs of patients. Utility systems that regulate the safe provision of water and air are inspected and maintained according to industry standards. Fire response measures are tested and analyzed for effectiveness. Emergency measures are in place to assure the well being and safety of patients when necessary. Hazardous wastes are contained and access to dangerous chemicals and combustible gas controlled. Emergency materials are available where needed to safely respond to emergencies, accidents and exposures. Back up communications methods are available to assure continuity of care during emergencies.

Medical equipment is inspected and tested according to manufacturer recommendations. Waived testing procedures include quality control measures to assure safety and reliability.

15. Infection Control
A comprehensive program to identify and reduce the risk of acquiring and transmitting infections among patients, visitors and staff is in place. Nosocomial infections are investigated and reduction strategies employed. Employee health and wellness measures help to prevent the spread of infection within the organization. Trends and patterns in infections are communicated to and from health officials to aid in control.

16. Nursing
Professional and paraprofessional nursing staff follow standards of patient care and standards of nursing practice to assure the safe and appropriate delivery of nursing care are on inpatient units twenty four hours per day, seven days per week. Psychiatric nurses provide direction and supervision in delivering safe care.

PATIENT SAFETY PRIORITIES
The Patient Safety Council establishes priorities for the organization in patient safety matters. Priorities may change at any time in response to actual or potential sentinel events, unusual or urgent events, unanticipated adverse occurrences, changing regulatory requirements, significant patient or staff need, changes in the environment of care or community needs, in response to performance improvement activities or at the request of the Governing Body.

PHILOSOPHY OF ERROR DETECTION AND RESPONSE
The delivery of safe health care is a complex matter dependent upon processes and functions that perform well, careful actions and judgments of staff, and patient participation in care planning and treatment. We continually assess our operations to assure error prevention strategies are effective. When actual or potential undesirable conditions or events occur, we respond immediately to assure the safety and well being of patients, visitors and staff.

When adverse events occur we strive to minimize individual blame. We view error identification as an opportunity to improve processes and systems that will result in better care. When sentinel events and significant events occur, or conditions are discovered that may contribute to such events, leaders and staff most knowledgeable about the process or system contributing to the event or condition, participate in conducting a root cause analysis to determine the underlying cause.

COORDINATION AND INTEGRATION OF PATIENT SAFETY
The risk of errors and adverse occurrences can be reduced when care and service is coordinated and integrated within an organization. The Patient Safety Council plans, organizes and coordinates practices that support or affect the safety of patient care delivery. The Patient Safety Council assures new services, changes in regulations, professional practices or accreditation requirements related to safety are coordinated and integrated in the organization. The Patient Safety Council reviews organizational policies and procedures for each point of service delivery or support to assure they are coordinated and patients, visitors and staff's safety are maintained. Practices, policies and procedures are revised as often as necessary to maintain the highest level of patient safety.

DESIGN AND REDESIGN OF FUNCTIONS, PROCESSES AND SYSTEMS
The Patient Safety Council designs and redesigns functions, processes and systems in response to Performance Improvement Activities, Sentinel Event Alerts, Root Cause Analysis Recommendations, proactive risk assessments, new program or services or when an opportunity to improve patient safety exists.

The Patient Safety Council intensely analyzes actual or proposed processes, systems and functions to determine potential failure modes and to identify error prevention strategies to protect patients from harm. Processes, systems and functions are designed or redesigned that incorporate sound principles of safety engineering and management and fail safe design.

SAFETY EDUCATION AND TRAINING
The Patient Safety Council coordinates staff, patient and visitor education and training programs in matters related to safety. Orientation and ongoing training programs for staff include general, department and job specific safety training including error detection and response, error prevention strategies and education to promote a safe environment for patients, visitors and staff.

BEST SAFETY PRACTICES
The Patient Safety Council serves as the organizational source for best practice safety standards. The Patient Safety Council incorporates both successful safety practices and lessons learned internally and from other organizations in promoting and maintaining the facility's highest level of patient safety.

Spring Mountain Treatment Center
ORGANIZATIONAL PLAN FOR PATIENT SAFETY

PURPOSE

Spring Mountain Treatment Center is committed to the well being and safety of patients. We acknowledge the process of health care delivery is complex and requires effective coordination within an organization to minimize the risks of adverse occurrences. We believe leaders must demonstrate the importance of patient safety through a comprehensive and non-punitive program for the prevention, detection and response to health care errors. We believe staff well trained in safety principles reduces the likelihood of errors. We believe an active partnership with the patients we serve will result in desired patient outcomes.

GOALS

The goals of the Organizational Plan for Patient Safety are:
1. Establish and maintain effective operational systems to prevent errors
2. Assure the safe delivery of care and services at Spring Mountain Treatment Center
3. Promote culture of patient safety priority
4. Foster non-punitive approach to error detection and response

OBJECTIVES
1. Establish priorities for Patient Safety
2. Coordinate functions, processes and systems related to patient and organizational safety within all services and departments
3. Design and redesign functions, processes and systems when an opportunity to improve patient safety exists
4. Incorporate best safety practices into organizational systems and processes
5. Provide interdisciplinary collaboration of safety in the environment of care
6. Standardize and integrate organization wide policies and procedures related to safety
7. Consider results of Performance Improvement activities in guiding safety
8. Respond to sentinel event and significant events requiring root cause analysis
9. Coordinate education and training for staff, patients and visitors related to safety
10. Utilize the Joint Commission National Patient Safety Goals as tools to improve safety and reduce errors
11. Incorporate Joint Commission Sentinel Event Alerts (applicable to Behavioral Health) into ongoing Patient Safety Process
12. Incorporate UHS Behavioral Health Division Risk Alerts into ongoing Patient Safety Process

STRUCTURE

Effective coordination and management of patient and organizational safety contributes to desired patient outcomes. The Patient Safety Council oversees the implementation of the Organization Plan for Patient Safety. The Patient Safety Council is chaired by the CEO and meets monthly, more often when necessary, to assure effective operation of

functions, processes and systems related to patient and organizational safety. Patient Safety Council members provide expert or first hand knowledge in safety aspects of clinical and administrative service delivery. Input from every department and services within the organization contributes to the well being and safety of patients. Patient Safety Council membership includes standing members who attend all Council meetings and "as needed" Council members who attend when necessary to effectively coordinate and integrate patient safety within the organization.

Patient Safety Council Standing Members:
1. CEO/Managing Director
2. Director of Performance Improvement
3. Medical Director
4. Director of Nursing
5. Risk Manager

SCOPE OF SERVICES
The Organizational Plan for Patient Safety involves all-important functions and processes that have the potential to affect the safety of services provided for inpatient and partial hospital programs.

1. Governance
   The Governing Body assumes ultimate responsibility for the safety of patients. The Governing Body approves the mission, vision and values of the organization affirming the importance of patient safety. The Governing Body delegates oversight of the Organizational Plan for Patient Safety to leaders. The Governing Body allocates sufficient financial and human resources to meet the safety needs of patients. The Governing Body assures the organization complies with applicable local, state, federal laws and regulatory requirements for patient safety. The Governing Body establishes the organizational structure for patient care responsibility. The Governing Body stays informed about adverse occurrences, Performance Improvement activities and pro-active risk reduction strategies.

2. Leadership
   Leaders implement the Organizational Plan for Patient Safety. Leaders foster a culture that promotes patient safety through a non-punitive approach to the detection and response to health care errors. Leaders approve important policies related to patient and organization safety. Leaders provide direction in carrying out the mission, vision and value of patient safety within the organization. Leaders assess the changing needs of the organization in order to maintain the highest level of patient safety. Leaders assure interdisciplinary coordination of patient and organizational safety. Leaders approve contracts for external services with reliable and credible vendors. Leaders identify sentinel events and significant events requiring root cause analysis and assure the timely and proper response to adverse events. Leaders are accountable for the safety of patients and the safe operation of the facility.

3. Management
Managers are responsible for the safe delivery of care and services within a specific branch of administrative or clinical operation. Managers are responsible for attaining and maintaining safety expertise within their scope of service delivery. Managers define safety aspects within their services or department and monitor the outcomes of performance for effects. Managers provide job specific safety training and assure department operations are integrated and coordinated within the organization.

4. Patient Rights, Responsibilities and Ethics
Patients have the right to expect safe care and services. Patients have the right to be informed of benefits and risks associated with proposed care. Patients have the right to be informed about outcomes of care including undesired and unexpected occurrences. Patients have the right to be informed about alternatives and possible results of refused care. Patients have the responsibility to participate in treatment as much as possible, to follow instructions, rules and regulations. Patients have the responsibility to provide accurate and reliable information, to report changes and to ask questions especially when care plans are not understood. Patients have the responsibility to respect the needs of others. Patients can expect that the facility has their well being and safety in mind. Patients can expect information that is honest and accurate. Patients can expect restrictions that are limited to only those necessary for safety. Patients can expect staff conduct that is ethical and safe.

5. Assessment of Patients
Assessment of patient safety needs is a dynamic process occurring through all points of service delivery. Assessment of patient safety includes physiological as well as psychosocial needs. The Admissions Department assesses whether the organization can meet the safety needs of patients desiring services. Professional assessment and reassessment of needs continues during the course of treatment in order to provide the proper database to make care decisions. Specialists assess the unique safety needs of adolescents as well as individuals who are victims of abuse or those requiring detoxification. Assessment of needs continues with the determination of safety requirements necessary for discharge or another level of care.

6. Care of the Patient
Safety is always a priority in the care of the patient. Therapeutic programs are designed with safety in mind and the milieu is managed to promote the safety of patients, visitors and staff. All care provided is under the guidance of a physician in collaboration with an interdisciplinary treatment team. Individualized care plans and interventions are based on current scientific knowledge and professional practices guidelines. The safety and well being of the patient is always considered in the care planning process and patients and their families are encouraged to participate as much as possible. Treatment expectations and outcomes of care are discussed with the patient and family as desired. When outcomes differ significantly from expectations or when adverse occurrences or

errors occur, the patient and family, as desired are informed including the consequences and how the course of care will be affected.

Direct observation is a primary method to determine the effects of care provided. Close observation or special precautions may be employed when necessary to assure safety of the patient. Assistance is provided when necessary to restore or to maintain the well being of patients; activities of daily living. Safe methods to respond to psychiatric and medical emergencies are implemented when necessary. Pharmaceutical services carefully control the ordering, delivery, storage and dispensing of medications to prevent errors. Dietary services provide the safe nutritional needs of the patients. Diagnostic tests and evaluations required by the patient's condition that are not available within the organization are provided by credible external sources. Safety provisions are in place to transport patients to and from facilities when necessary.

7. Management of Human Resources
    A sufficient amount of qualified staff are provided to assure the safety of patients. Job descriptions define performance expectations related to patient and organization safety. General, department and job specific orientation focuses on safety matters including definitions of errors, how they are reported, managed and prevented. Initial, annual and ongoing competency determination confirms the knowledge and skills necessary to perform important safety aspects of job functions. Additional on the job training in equipment and skill application maintain the abilities of staff to provide safe quality care. Orientation, training and education in safety is revised when necessary based on emerging needs of patients, visitors and staff. When work performance affects or has the potential to affect patient safety or when sentinel events or significant events occur, Human Resources provides additional training, education and employee assistance.

8. Management of Information
    Patient information is coordinated amongst providers and users prior to service entry, during the course of care and after discharge. Electronic information and written medical records are available at points of service. The care of the patient and response to treatment is permanently maintained in clinical records. Authorization is required prior to the release or discussion of confidential patient information. Professional information sources are provided through internet and current literature subscriptions.

9. Medical Staff
    Medical Staff Bylaws and Rules and Regulations define performance expectations for licensed independent practitioners. The appointment and reappointment process assures practitioners are qualified and competent to provide privileges. Peer Review activities evaluate the safety and effectiveness of care provided. The physician's health program provides services to medical staff to assure they maintain the ability to provide safe care to patients.

10. Performance Improvement
Performance Improvement monitors measure, assess, and improve important aspects of organization safety including high risk and problem prone services. Internal and external comparison sources provide a means to evaluate performance. When trends or patterns indicate a quality concern intense analysis is conducted to determine cause. New processes and redesigned processes are evaluated for effectiveness. Sentinel Event Alerts warrant an examination of processes to determine if the potential to reduce risk of adverse occurrences exists. Improvement strategies and best practice standards are communicated within the organization.

The Risk Management Program identifies potential and actual risks to the organization and welfare of patients. Complaints are investigated and incidents analyzed. Processes to eliminate hazards and losses are implemented and evaluated for effectiveness. Contract provider performance is evaluated for quality and safety and claims litigation is managed.

11. Patient Education
Education is provided to patients and families that promotes safety and enhances recovery. Individual education plans may include disease, pain and medication management, health teaching, coping strategies, proper nutrition, self-care, use of equipment and community resources. Comprehension of education learned is validated to avoid mistakes. Specialists provide academic education to children and adolescents as necessary.

12. Perception of Care
Patients, visitors and staff are encouraged to submit comments about the care provided as well as suggestions to improve safety and services through the Patient Satisfaction Survey. Responses are reviewed and considered by leaders. Staff are commended when their ideas results in improved safety or service. Patients anonymously complete satisfaction surveys upon discharge and rate their perception of the safety of care received. In addition, patients are encouraged to submit suggestions on the satisfaction survey about ideas to improve safety conditions. Findings are analyzed and considered in process and system design.

13. Continuum of Care
Care needs determine the level of services provided. Safety needs may trigger a change in the level of care. Processes assure prompt transition to a different level of care when necessary. Continued care and education needs identified during the course of treatment are coordinated and planned with the patient, family and alternate service provider in preparation for discharge to assure a smooth and safety transition.

14. Environment of Care
The physical plan and patient unit designs consider the unique safety needs of the behavioral healthcare population including services to children, adolescents,

adults and older adults. Furnishings and fixtures are selected that are age appropriate and provide the safest environment of care. Internal and external space and traffic flow is planned to minimize the risks of injury to patients, visitors and staff. Safety measures are incorporated in rooms designated for the purpose of seclusion. Access to sharp and dangerous objects are controlled. The environment of care is frequently inspected for safety conditions and repairs made promptly to avoid injury. Building and construction planning complies with Life Safety Codes and considers the safety and comfort needs of patients. Utility systems that regulate the safe provision of water and air are inspected and maintained according to industry standards. Fire response measures are tested and analyzed for effectiveness. Emergency measures are in place to assure the well being and safety of patients when necessary. Hazardous wastes are contained and access to dangerous chemicals and combustible gas controlled. Emergency materials are available where needed to safely respond to emergencies, accidents and exposures. Back up communications methods are available to assure continuity of care during emergencies.

Medical equipment is inspected and tested according to manufacturer recommendations. Waived testing procedures include quality control measures to assure safety and reliability.

15. Infection Control
A comprehensive program to identify and reduce the risk of acquiring and transmitting infections among patients, visitors and staff is in place. Nosocomial infections are investigated and reduction strategies employed. Employee health and wellness measures help to prevent the spread of infection within the organization. Trends and patterns in infections are communicated to and from health officials to aid in control.

16. Nursing
Professional and paraprofessional nursing staff follow standards of patient care and standards of nursing practice to assure the safe and appropriate delivery of nursing care are on inpatient units twenty four hours per day, seven days per week. Psychiatric nurses provide direction and supervision in delivering safe care.

PATIENT SAFETY PRIORITIES
The Patient Safety Council establishes priorities for the organization in patient safety matters. Priorities may change at any time in response to actual or potential sentinel events, unusual or urgent events, unanticipated adverse occurrences, changing regulatory requirements, significant patient or staff need, changes in the environment of care or community needs, in response to performance improvement activities or at the request of the Governing Body.

PHILOSOPHY OF ERROR DETECTION AND RESPONSE
The delivery of safe health care is a complex matter dependent upon processes and functions that perform well, careful actions and judgments of staff, and patient participation in care planning and treatment. We continually assess our operations to assure error prevention strategies are effective. When actual or potential undesirable conditions or events occur, we respond immediately to assure the safety and well being of patients, visitors and staff.

When adverse events occur we strive to minimize individual blame. We view error identification as an opportunity to improve processes and systems that will result in better care. When sentinel events and significant events occur, or conditions are discovered that may contribute to such events, leaders and staff most knowledgeable about the process or system contributing to the event or condition, participate in conducting a root cause analysis to determine the underlying cause.

COORDINATION AND INTEGRATION OF PATIENT SAFETY
The risk of errors and adverse occurrences can be reduced when care and service is coordinated and integrated within an organization. The Patient Safety Council plans, organizes and coordinates practices that support or affect the safety of patient care delivery. The Patient Safety Council assures new services, changes in regulations, professional practices or accreditation requirements related to safety are coordinated and integrated in the organization. The Patient Safety Council reviews organizational policies and procedures for each point of service delivery or support to assure they are coordinated and patients, visitors and staff's safety are maintained. Practices, policies and procedures are revised as often as necessary to maintain the highest level of patient safety.

DESIGN AND REDESIGN OF FUNCTIONS, PROCESSES AND SYSTEMS
The Patient Safety Council designs and redesigns functions, processes and systems in response to Performance Improvement Activities, Sentinel Event Alerts, Root Cause Analysis Recommendations, proactive risk assessments, new program or services or when an opportunity to improve patient safety exists.

The Patient Safety Council intensely analyzes actual or proposed processes, systems and functions to determine potential failure modes and to identify error prevention strategies to protect patients from harm. Processes, systems and functions are designed or redesigned that incorporate sound principles of safety engineering and management and fail safe design.

SAFETY EDUCATION AND TRAINING
The Patient Safety Council coordinates staff, patient and visitor education and training programs in matters related to safety. Orientation and ongoing training programs for staff include general, department and job specific safety training including error detection and response, error prevention strategies and education to promote a safe environment for patients, visitors and staff.

BEST SAFETY PRACTICES

The Patient Safety Council serves as the organizational source for best practice safety standards. The Patient Safety Council incorporates both successful safety practices and lessons learned internally and from other organizations in promoting and maintaining the facility's highest level of patient safety.

Policy Title:	Patient Safety Plan		
Location:	Spring Valley Hospital	Department:	Housewide
Policy Number:		Next Review Date:	1/2016
Original Effective Date:		Current Effective Date:	1/2015

I. Purpose:

A. The purpose of the Patient Safety Plan (the Plan) at Spring Valley Hospital Medical Center (the 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; and

   g. Support of the sharing of that knowledge to effect behavioral changes in itself and other health care organizations.

B. The 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.

II. Policy:

Because 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 patient safety activities at the Hospital. The Patient Safety Plan, developed by the interdisciplinary Patient Safety Council and approved by the medical staff, VHS Governing Board and Administration, outlines the components of the organizational Patient Safety Plan. The VHS Governing Board further delegates the Patient Safety Committee to review all formal patient grievances on a quarterly basis and ensure that resolution is achieved and provide direction for activities to decrease and/or prevent reoccurrences of those issues. All formal grievances and responses will be reviewed by no less than two members of this Committee.

III. Introduction:

The intent of the Patient Safety Plan is to create, maintain and sustain a safety-oriented just culture for the Hospital. The safe-oriented just culture is to provide a clinically safe environment for patients, visitors, physicians, staff and volunteers.

This safety-oriented just culture promotes the identification and reporting of actual events and potential risks to patient safety. The Hospital's leaders support behaviors and actions that:

A. Prevent medical errors or events

B. Focus on processes and system failures when events occur.

C. Minimize individual blame or retribution.

D. Conduct proactive risk reduction assessments of high-risk processes based on Sentinel Events Alerts published by The Joint Commission (TJC) or any accrediting agency and/or high-risk processes or systems as identified by the organization.

E. Communicate events through internal reporting.

F. Support sharing and learning of information to affect change in behavior and processes.

IV. **Goals:**

A. Establish an organization-wide patient safety-oriented just culture.

B. Implement interdisciplinary education/training of patient safety standards, Plan, and individual accountability.

C. Improve patient safety through ongoing proactive assessment and use of tools such as root cause analysis and failure mode effect analysis.

D. Implement immediate response processes to sentinel events.

E. Implement response and processes to unanticipated/unexpected events.

F. Assess the resource allocation for patient safety.

G. Implement process/system for compliance with National Patient Safety Goals.

H. Measure and aggregate safety data to achieve reduction in events/errors or injury.

I. Establish a reporting system that promotes and supports a just culture.

J. Establish monitoring indicators that demonstrate effectiveness of the Patient Safety Plan.

V. **Scope:**

A. The Patient Safety Plan is a collaborative plan with Universal Health Services, Inc. (UHS) Corporate Risk Management and quality initiatives and an organization-wide plan and is applicable to all departments as defined in the Hospital's organization chart. The Plan includes acute care inpatient, outpatient, and ambulatory services, and diagnostic and treatment areas. There are no exceptions to this Plan.

B. The Patient Safety Plan is intended to provide a systematic, coordinated and continuous approach to patient safety. Activities and functions of the Patient Safety Plan are integrated within all functions and activities of patient care and delivery of services. The activities listed below are considered the core activities of this Plan, but are not limited to these activities:

1. Establish visible, consistent focus on patient safety and risk reduction of events.

2. Assess all medical/health care events ranging from no harm events to sentinel events.

3. Conduct proactive risk reduction assessments of high-risk processes based on Sentinel Event Alerts published by TJC or any accrediting agency or high-risk processes or systems identified.

4. Train and educate for patient safety.

5. Coordinate and direct activities addressing published Sentinel Event Alerts.

6. Integrate departments and staff participation in the Plan.

7. Participate/conduct root cause analysis for sentinel events, unexpected events or potential events.

8. Conduct proactive risk assessments including use of root cause analysis and failure mode effective analysis.

9. Establish a reporting system that promoted a non-punitive just culture and promotes reporting of events or potential events.

10. Focus opportunities on processes and systems and not on individual performance.

11. Establish patient safety priorities in the design and redesign of services, processes and systems.

12. Assess, measure, analyze safety event data to determine effectiveness of the Plan, or identify trends, patterns or opportunities for improvement. Prioritize patient safety opportunities according to criteria.

13. Integrate all patient safety activities into the Performance Improvement Programs.

VI.   Structure:

Management of the Plan:

This Plan is implemented, coordinated and directed by the Director of Risk Management/Patient Safety and the Patient Safety Council. The Patient Safety Council is an interdisciplinary committee comprised of medical staff leaders, administration, risk management, quality management, infection control, pharmacy, and ad hoc departments such as, but not limited to, admitting, medical records, and clinical disciplines such as, but not limited to, nursing, radiology, nutritional services, social services, physicians, therapy, cardiopulmonary, laboratory and maternal/child services representatives. The Patient Safety Council functions in collaboration with other hospital and medical staff committees, such as, but not limited to, Performance Improvement Committees, (PPIC & HPIC), and the Medical Executive Committee (MEC). The Patient Safety Council will meet monthly unless prior approval is obtained to cancel by the area UHS Corporate Risk Manager.

VII.   Chair of Patient Safety Council will be the Director of Risk Management

A. The Patient Safety Council functions in collaboration with the Performance Improvement Committee and reports directly to the MEC and to the VHS Governing Board. In addition, the Patient Safety Council provides reports to Corporate Risk Management and Quality Management.

B. Director of Risk Management/Patient Safety has the following responsibilities:
   1. Implement and direct all aspects of the Patient Safety Plan.
   2. Direct development of processes for
      a. Sentinel Event Review

1. Root cause analysis
2. Identification of opportunities related to root cause analysis
3. Implementation of improvements
4. Measurement of improvements

   b. Sentinel Event Alert Review Processes
1. Assessment of current practice
2. Implementation of improvements
3. Conduct proactive risk assessment and failure mode effect analysis
4. Facilitate integration with Quality/Performance Improvement and Risk Management activities
5. Facilitate education on patient safety.
6. Facilitate measurement for safety events and technology to support the Plan.
7. Facilitate communication of patient safety findings, opportunities, and improvements throughout the Hospital.
8. Serve as internal resource on patient safety standards for the organization.
9. Serve as Patient Safety Officer.

VIII. The Director of Risk Management/Patient Safety has a hospital-wide function, with the authority to review, assess, analyze, and conduct root cause analysis or failure mode effect analysis of any event, process, or systems that relate to a potential risk to patient safety regardless of department or management structure.

Patient Safety Council Goals are as defined in Section IV.

IX. Integration and Coordination:

   A. The Patient Safety Plan functions in collaboration and integration with all corporate and organization departments, policies and procedures, and established plans. This integration is accomplished through interdisciplinary membership on committees, such as, but not limited to, Performance Improvement Committees, HPIC and PPIC, and other subcommittees as chartered through the Performance Improvement Program.

   B. Systematic measurement of the effectiveness of the program.

X. Communication with Patients:

   A. All patients will receive education related to patient safety and their environment on point of entry to service/diagnostic area or treatment area. The education will be specific to the area and the patient needs.

   B. In accordance with patient rights, patients, and when appropriate, family/significant other, will be informed about outcome of care, including unanticipated outcomes or when outcomes differ from expected. The attending physician or designee is responsible for informing the patient and/or family. Additional interdisciplinary members may be included in this communication as appropriate.

XI. Staff Education:

Staff will receive education and training during their orientation and on an ongoing basis regarding job-specific aspects of patient safety, the National Patient Safety Goals including team training and the reporting of events.

XII. Safety Improvement Activities:

A. Definition of Terms:

1. No Harm Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome; those that do not result in a physical or psychological negative outcome or have the potential for negative outcome for the patient.

2. Mid-Moderate Adverse Outcome Errors – those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient and that require short-term medical intervention and/or result in an increased length of stay.

3. Significant Medication Errors or any identified trends in Medication Errors that result in an adverse patient outcome.

4. Any Adverse Drug Reaction – an expected/unexpected, undesired, unintended, excessive or exaggerated effect of a drug.

5. Confirmed Transfusion Reaction to Blood Products.

6. Hazardous Condition – any set of circumstances, exclusive of the disease or condition for which the patient is being treated, that significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

7. Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof (Near Miss). Any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel Event criteria includes:

    a. Unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

    b. Unanticipated death or major permanent loss of function attributed to a nosocomial infection (i.e., except for an infection from which the patient would probably not have died or suffered loss of function).

    c. Unanticipated death of a full-term infant.

    d. 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.

    e. Suicide of a patient in a setting where the patient receives around-the-clock care.

    f. Infant or child abduction or discharge to the wrong family member.

    g. Rape (unconsented sexual contact).

    h. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

    i. Surgery on the incorrect patient or incorrect body part or incorrect procedure.

  8. Environment of care significant incidents involving employee, visitor, utility or property damage.

B. Patient Safety Prioritization of Improvement Activities

  1. Improvement activities are prioritized according to set criteria, that includes: compliance related to accrediting standards, National Patient Safety Goals, or error prone or high risk processes, mission/vision/values, strategic/operational goals and cost/benefit analysis. These priorities will be determined by leaders of the organization and members of the Patient Safety Council.

C. Routine Safety-Related Data Collection and Analysis

  1. Health Care Peer Review Report

    a. All departments within the organization (clinical and support) are responsible to report any patient safety events, and potential events by the completion of an on-line incident report. This report is then electronically routed to Risk Management. Risk Management screens all reports for potential sentinel events or unexpected events/outcomes. Risk Management will communicate on an ongoing basis with department managers and staff regarding clinical events, such as patient falls, medication errors, treatment errors or unexpected outcomes.

    b. Risk Management will provide data, data analysis of events to the Patient Safety Council, PPIC and HPIC, MEC and VHS Governing Board on a systematic basis.

    c. Opportunities, patterns or trends will be identified and actions taken for improvement in interdisciplinary committees.

  2. Medication Error

    a. Medication event data will be collected on an ongoing basis, with analysis of events and actions taken on opportunities.

  3. Infection Surveillance

    a. Surveillance and monitoring will be accomplished in accordance with the Infection Prevention Plan.

  4. Facility Safety Surveillance

    a. These activities will be accomplished in accordance with the Environment of Care Plans, but will be integrated as appropriate to patient safety.

  5. Staff Perception of and Suggestions for Improving Patient Safety

    a. An annual survey of staff, including physicians, all disciplines and support staff, will be conducted to seek suggestions for improving patient safety. Staff willingness to report errors will be included in this survey. This data will be analyzed and presented in the annual evaluation of the Plan. Opportunities for improvement will be prioritized and implemented through the Patient Safety Council.

6. Patient/Family Perception of and Suggestions for Improving Patient Safety
   a. The hospital-wide patient satisfaction survey will include questions on patient perception of safety and requests for suggestions in safety. This data will be reported quarterly to the Patient Safety Council. Opportunities and improvements will be implemented as indicated and as appropriate to opportunities.
7. Identification, Reporting and Management of Sentinel or Unexpected Event or Outcome
   a. Upon identification of a medical/health care event, the patient care provider will:
      1. Perform necessary health care interventions to protect and support the clinical condition
      2. Contact the attending physician and consulting physicians, as appropriate, to report error
      3. Implement physician orders as appropriate
      4. Preserve information related to the event/error
      5. Document the facts of the event/error in the medical record according to policy/procedure
      6. Report event/error to immediate supervisor
      7. Immediate supervisor/manager will contact Risk Management, as appropriate
      8. Submit an incident report according to policy/procedure
      9. The Director of Risk Management will review all events/errors that meet the definition of Sentinel Event, Near Miss, Significant Medication Error or unexpected outcomes as appropriate.
      10. Staff members involved in a sentinel event, near miss, significant medication error or unexpected outcome will receive support regarding staff member's professional and emotional reconciliation of event/error. Support may be through Employee Assistance Program and Human Resources.
      11. The Director of Risk Management will determine follow-up actions such as, but not limited to, root cause analysis and/or referral to Peer Review.
      12. Any Sentinel Event, Near Miss, Significant Medication Error, or unexpected outcome will be reported to the Patient Safety Council, HPIC, PPIC, MEC and VHS Governing Board as appropriate.
8. Proactive Risk Reduction Activities or FMEA:
   a. The proactive assessment will include, but not be limited to:
      1. Assess the intended and actual implementation of the process to identify the steps for possible and actual variation using the failure modes analysis.
      2. For each failure mode, identify the possible effects of the undesirable variation on patients and how serious the possible effect could be.
      3. For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to the effect may occur.

4. Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or protect patient from the effects of that undesirable variation.
5. Test and implement the redesigned process.
6. Identify and implement measures of the effectiveness of the redesigned process.
7. Implement a strategy for maintaining the effectiveness of the redesigned process over time.
8. Proactive assessment and action will be reported to the Patient Safety Council, HPIC, PPIC, MEC and VHS Governing Board, as appropriate.
9. Communication to leadership, Hospital, medical staff committee and departments will be facilitated by the Director of Risk Management.

9. Patient Safety Checklists

   a. Effective July 1, 2011, Patient Safety Checklists will be utilized where appropriate as the committee determines necessary and by state statute and be reviewed and revised as appropriate annually.*

D. Confidentiality

The Patient Safety Council functions in collaboration with the Performance Improvement Program. The Performance Improvement Plan confidentiality would be applicable to the Plan and Patient Safety Committee.

XIII. Program/Plan Evaluation:

A. An annual evaluation of the Program/Plan will be conducted and reported to the Patient Safety Council, PPIC, HPIC, MEC, and the VHS Governing Board. The evaluation will include, but is not limited to, the following:

1. National Patient Safety Indicators/Measures
2. Data from Information Management Needs Assessment
3. Staff Education Needs Assessment
4. Proactive Risk Assessments
5. Incident/Event Reports
6. Sentinel Events
7. Root Cause Analysis
8. Failure Mode Analysis
9. Patient Satisfaction Surveys
10. Staff Survey

B. Based on this evaluation, Plan and goal revisions will be recommended to the Patient Safety Council, PPIC, HPIC, MEC and VHS Governing Board.

XIV. References:

Nevada Assembly Bill No. 280 (AB280)

PATIENT SAFETY/RISK MANAGEMENT PLAN
FY 2016
ROSE DE LIMA CAMPUS

PURPOSE

To establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program designed to promote and improve patient safety at Dignity Health - St. Rose Dominican Rose de Lima Campus, by preventing medical/healthcare adverse events and reducing risk to patients and visitors.

POLICY

The Patient Safety/Risk Management Program for Rose de Lima Campus includes campus specific collection and analysis of patient safety work products, Dignity Health Patient Safety Standards, Shared Learnings, Mistake Management Philosophy, integration with the Performance Improvement Plan and is approved by the Community Board, Medical Staff and Senior Leadership. The program participates in the California Hospital Patient Safety Organization (CHPSO) to provide a coordinated and systematic campus specific approach to developing an information infrastructure and build better evidence-based improvement activities for patient safety, a critical component to reducing medical/healthcare events and improving the delivery of safe patient care .

Patient Safety Program and Performance Improvement

St. Rose Dominican Rose de Lima is committed to making the safety of all patients, employees, physicians and visitors a leadership priority for organizational performance improvement. The Patient Safety/Risk Management Program utilizes patient safety work products to encourage a culture of safety and provide feedback to each campus and assistance toward minimizing patient risk that includes processes to:

- Establish and maintain a culture of safety;
- Promote safety by collecting and analysis of patient safety work product to recognize and develop strategies to reduce risks and hazardous conditions that result in medical/healthcare events and patient injury;
- Support a strong internal non-punitive reporting mechanism;
- Facilitate the rapid redesign of unsafe care processes and systems in response to actual and potential adverse events;
- Support ongoing proactive efforts through implementation of known safe practices such as patient safety checklists and patient safety policies;
- Promote communication and coordination among individuals and departments to minimize risk to patients;
- Support notification of patients and when appropriate, their family, of unplanned outcomes;

- Utilize Dignity Health and SRDH data collection systems to monitor performance of new or revised processes including patient, family and staff input, needs, perceptions of risk to patients and suggestions for improvement.
- Support The Joint Commission (TJC) National Patient Safety Goals, Dignity Health Shared Learnings and other patient safety related initiatives such as IHI, etc. as proactive methods for risk reduction and patient safety initiatives.

Organizational Culture

An organizational culture has been established by the leaders of Dignity Health - St. Rose Dominican Rose de Lima that support the effective reduction of medical/healthcare events and other factors that contribute to unintended adverse patient outcomes. This culture is based on the principles of organization-wide cooperation and communication and encourages:

- The recognition and acknowledgement that preventing events and improving safety for patients requires a systems approach in order to modify the conditions that contribute to events;
- A focus on processes and systems including Infection Prevention; human factors; and education. Promotion of a just culture and minimization of individual blame or retribution for involvement in a medical/healthcare event;
- Internal sharing of trends/event evaluation and the actions taken to reduce risk
- Organizational learning about medical trends/best practices to affect the outcomes including unanticipated events.
- Participation in the CHPSO for enhancement of our activities to improve patient safety and the quality of health care delivered within the SRDH system

The organizational culture is also reflective of the Risk Mistake Management Philosophy, which supports the patient's right to be informed about the outcomes of their care, including unanticipated outcomes.

An effective Patient Safety/Risk Management Program cannot exist without optimal reporting of actual or potential medical/health care events and occurrences. Therefore, it is the intent of all Dignity Health -St. Rose Dominican hospitals to adopt a "just culture" approach in its management of events and occurrences. All personnel will report suspected or actual medical/healthcare event and may do so without fear of reprisal.

Scope of Activities

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 service.

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 undesirably 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 reactions
    - 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).
- NPSG audits to be completed at each campus by individual Departments utilizing a Performance Improvement Management System (PIMS) according to the Dignity Health audit criteria.

Leadership

The Dignity Health - St. Rose Dominican Community 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 defined, 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
- Annually evaluate the patient safety plan for its effectiveness in reducing risk and improving patient safety.
- Active participation in the California Hospital Patient Safety Organization (CHPSO)

Patient Safety Officer

The Director of Quality 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 include:

- Day to day responsibility for the Patient Safety 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

PATIENT SAFETY COMMITTEE

The Patient Safety Committee convenes monthly in accordance with NRS439.875. 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 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 Interdisciplinary Committee 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.

Physicians

Physicians are responsible, as participants in the patient safety 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 pain 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 those activities include:

- Active participation in the activities to improve patient safety and the quality of health care delivered.
- Adherence to Infection Prevention Measures; TJC National Patient Safety Goals and other patient safety initiatives.
- Participation in all 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 the information needs assessment, staff surveys and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all medication events (including near misses), even if they do not reach the patient, in collaboration with the Pharmacy.
- Reporting all events and process variances (harm or no harm), even if they do not reach the patient (near misses).

PROGRAM

I. Proactive Risk Assessment Activities

    A.   The Risk Management/Patient Safety Department, in collaboration with the various facility Committees including Infection Prevention, Interdisciplinary 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:

        1.   An initial patient safety risk assessment evaluating known high risk processes/procedures that have associated risks;

        2.   Participation in an annual employee safety survey process in collaboration with Dignity Health, to include follow-up on areas not meeting goals;

        3.   On-going risk assessments based on internal and external data, including sentinel event alerts;

        4.   Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.

        5.   Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of Rose de Lima campus.

        6.   Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.

        7.   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.

        8.   Infection Prevention Surveillance Program

        9.   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.

    B.   Risk assessment activity results will be aggregated and analyzed. Appropriate department/process action plans will be developed in response to the results with the goal of reducing the actual, potential or perceived risk to patient safety.

II. Event Reporting

Rose de Lima actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration, and evaluations 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 the Regulation**. (**See Event Reporting and Management Policy.)

A.   When an unplanned event/process variance occurs, the patient care provider will do the following:

   1.   Perform the necessary healthcare interventions to support the patient's clinical condition.
   2.   Perform the necessary interventions to contain the risks to others.
   3.   Notify the patient's attending physician.
   4.   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.
   5.   Notify immediate supervisor of the event.
   6.   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:

   1.   Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
   2.   Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

III. 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, Interdisciplinary and Environment of Care for analysis and action. Based on analysis of this data, 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:

   1.   Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
   2.   Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
   3.   For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
   4.   Redesign of the process and/or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
   5.   Test and implement the redesign process;
   6.   Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and

7. Implementation of a strategy for maintaining the effectiveness of the process over time.
8. Events that do not require a Root Cause Analysis will have a Performance Improvement Event Review (PIER) completed by the Quality/Risk Management as soon as practicable of becoming aware of the event. The results will be forwarded to Leadership for review.

IV. 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), PIER and/or a failure mode and effects analysis (FMEA), implement in action plan to reduce further risk to patients and establish measures of effectiveness as described above in Section III A.

1. The following events always elicit an intense analysis:

   a. Confirmed transfusion reactions;
   b. Significant adverse drug reactions;
   c. Significant medication events and hazardous conditions;
   d. Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
   e. Significant adverse events associated with anesthesia use.
   f. Hospital acquired infections
   g. All events meeting the definition of Sentinel Events in the State of Nevada.

2. A root cause analysis is performed when a sentinel or State reportable event occurs.
3. A PIER analysis 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.

1. 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.
2. Involved staff should be involved in the root cause analysis process.
3. The Department Manager will provide on-going support to the staff member(s) as needed.

4. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

V. Education

A. Staff Education

1. General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety and risk reduction strategies.
2. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
   - An overview of the Patient Safety Program
   - Overview of the TJC National Patient Safety Goals
   - Staff's role and responsibilities in the Patient Safety/Risk Management Program
   - Event reporting criteria and process
   - 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.
3. 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

1. 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.
2. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

VI. 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 stated including but not limited to medical staff, Interdisciplinary 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 Medical Executive Committee.

C.   Annually, the Patient Safety/Risk Management Program will be evaluated for effectiveness and the program updated to reflect the results of risk assessments of patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.

   1.   The review will be approved by QCAC.
   2.   Will be submitted to the Community Board for final review and approval.

Revision Reviewed/Approved:
Patient Safety Committee, April 20, 2015
Quality Care Advisory Committee of the Board, May 8, 2015
Community Board, May 28, 2015

References:
NRS Chapter 439
California Hospital Patient Safety Organization
Infection Prevention Plan
Performance Improvement Plan

PATIENT SAFETY/RISK MANAGEMENT PLAN
FY 2016
SAN MARTIN CAMPUS

PURPOSE

To establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program designed to promote and improve patient safety at Dignity Health - St. Rose Dominican San Martin Campus, by preventing medical/healthcare adverse events and reducing risk to patients and visitors.

POLICY

The Patient Safety/Risk Management Program for San Martin Campus includes campus specific collection and analysis of patient safety work products, Dignity Health Patient Safety Standards, Shared Learnings, Mistake Management Philosophy, integration with the Performance Improvement Plan and is approved by the Community Board, Medical Staff and Senior Leadership. The program participates in the California Hospital Patient Safety Organization (CHPSO) to provide a coordinated and systematic campus specific approach to developing an information infrastructure and build better evidence-based improvement activities for patient safety, a critical component to reducing medical/healthcare events and improving the delivery of safe patient care.

Patient Safety Program and Performance Improvement

Dignity Health - St. Rose Dominican San Martin Campus is committed to making the safety of all patients, employees, physicians and visitors a leadership priority for organizational performance improvement. The Patient Safety/Risk Management Program utilizes patient safety work products to encourage a culture of safety and provide feedback to each campus and assistance toward minimizing patient risk that includes processes to:

- Establish and maintain a culture of safety;
- Promote safety by collecting and analysis of patient safety work product to recognize and develop strategies to reduce risks and hazardous conditions that result in medical/healthcare events and patient injury;
- Support a strong internal non-punitive reporting mechanism;
- Facilitate the rapid redesign of unsafe care processes and systems in response to actual and potential adverse events;
- Support ongoing proactive efforts through implementation of known safe practices such as patient safety checklists and patient safety policies;
- Promote communication and coordination among individuals and departments to minimize risk to patients;

- Support notification of patients and when appropriate, their family, of unplanned outcomes;
- Utilize Dignity Health and SRDH data collection systems to monitor performance of new or revised processes including patient, family and staff input, needs, perceptions of risk to patients and suggestions for improvement.
- Support The Joint Commission (TJC) National Patient Safety Goals, Dignity Health Shared Learnings and other patient safety related initiatives such as IHI, etc. as proactive methods for risk reduction and patient safety initiatives.

Organizational Culture

An organizational culture has been established by the leaders of St. Rose Dominican San Martin that support the effective reduction of medical/healthcare events and other factors that contribute to unintended adverse patient outcomes. This culture is based on the principles of organization-wide cooperation and communication and encourages:

- The recognition and acknowledgement that preventing events and improving safety for patients requires a systems approach in order to modify the conditions that contribute to events;
- A focus on processes and systems including Infection Prevention; human factors; and education. Promotion of a just culture and minimization of individual blame or retribution for involvement in a medical/healthcare event;
- Internal sharing of trends/event evaluation and the actions taken to reduce risk;
- Organizational learning about medical trends/best practices to affect the outcomes including unanticipated events.
- Participation in the CHPSO for enhancement of our activities to improve patient safety and the quality of health care delivered within the SRDH system

The organizational culture is also reflective of the Risk Mistake Management Philosophy, which supports the patient's right to be informed about the outcomes of their care, including unanticipated outcomes.

An effective Patient Safety/Risk Management Program cannot exist without optimal reporting of actual or potential medical/health care events and occurrences. Therefore, it is the intent of all Dignity Health - St. Rose Dominican hospitals to adopt a "just culture" approach in its management of events and occurrences. All personnel will report suspected or actual medical/healthcare event and may do so without fear of reprisal.

Scope of Activities

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 service.

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 undesirably 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 reactions
  - 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).
- NPSG audits to be completed at each campus by individual Departments utilizing a Performance Improvement Management System (PIMS) according to the Dignity Health audit criteria.

Leadership

The Dignity Health - St. Rose Dominican Community 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 defined, 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;
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- Annually evaluate the patient safety plan for its effectiveness in reducing risk and improving patient safety.
- Active participation in the California Hospital Patient Safety Organization (CHPSO)

Patient Safety Officer

The Director of Quality 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 include:

- Day to day responsibility for the Patient Safety 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

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 has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety/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.;
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- Annual review of the Patient Safety Program to ensure its appropriateness of focus and effectiveness of efforts for each campus.

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Physicians are responsible, as participants in the patient safety 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.
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Hospital Departments and Staff

San Martin staff are key to promoting, identifying, and implementing activities to reduce risk and improve patient safety. Some of those activities include:

- Active participation in the activities to improve patient safety and the quality of health care delivered.
- Adherence to Infection Prevention Measures; TJC National Patient Safety Goals and other patient safety initiatives.
- Participation in all 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 the information needs assessment, staff surveys and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all medication events (including near misses) even if they do not reach the patient in collaboration with the Pharmacy.
- Reporting all events and process variances (harm or no harm) even if they do not reach the patient (near misses).

PROGRAM

I. Proactive Risk Assessment Activities

A. The Risk Management/Patient Safety Department, in collaboration with the various facility Committees including Infection Prevention, Interdisciplinary 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:

1. An initial patient safety risk assessment evaluating known high risk processes/procedures that have associated risks;
2. Participation in an annual employee safety survey process in collaboration with Dignity Health, to include follow-up on areas not meeting goals;
3. On-going risk assessments based on internal and external data, including sentinel event alerts;
4. Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.
5. Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of San Martin campus.
6. Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.
7. 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.
8. Infection Prevention Surveillance Program
9. 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.

B. Risk assessment activity results will be aggregated and analyzed. Appropriate department/process action plans will be developed in response to the results with the goal of reducing the actual, potential or perceived risk to patient safety.

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San Martin actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration, and evaluations 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 the Regulation. (See Event Reporting and Management Policy.)

A. When an unplanned event/process variance occurs, the patient care provider will do the following:

1. Perform the necessary healthcare interventions to support the patient's clinical condition.
2. Perform the necessary interventions to contain the risks to others.
3. Notify the patient's attending physician.
4. 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.
5. Notify immediate supervisor of the event.
6. 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:

1. Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
2. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

III. 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, Interdisciplinary and Environment of Care for analysis and action. Based on analysis of this data, 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:

1. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
2. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
3. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
4. Redesign of the process and/or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
5. Test and implement the redesign process;

6. Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and
7. Implementation of a strategy for maintaining the effectiveness of the process over time.
8. Events that do not require a Root Cause Analysis will have a Performance Improvement Event Review (PIER) completed by the Quality/Risk Management as soon as practicable of becoming aware of the event. The results will be forwarded to Leadership for review.

IV. 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), PIER and/or a failure mode and effects analysis (FMEA), implement in action plan to reduce further risk to patients and establish measures of effectiveness as described above in Section III A.

   1. The following events always elicit an intense analysis:

      a. Confirmed transfusion reactions;
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      c. Significant medication events and hazardous conditions;
      d. Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
      e. Significant adverse events associated with anesthesia use.
      f. Hospital acquired infections
      g. All events meeting the definition of Sentinel Events in the State of Nevada.

   2. A root cause analysis is performed when a sentinel or State reportable event occurs.
   3. A PIER analysis 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.

   1. 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.
   2. Involved staff should be involved in the root cause analysis process.

3. The Department Manager will provide on-going support to the staff member(s) as needed.
4. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

V. Education

A. Staff Education

1. General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety and risk reduction strategies.
2. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
   - An overview of the Patient Safety Program
   - Overview of the TJC National Patient Safety Goals
   - Staff's role and responsibilities in the Patient Safety/Risk Management Program
   - Event reporting criteria and process
   - 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.
3. 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

1. 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.
2. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

VI. 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 stated including but not limited to medical staff, Interdisciplinary 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 Medical Executive Committee.

C.   Annually, the Patient Safety/Risk Management Program will be evaluated for effectiveness and the program updated to reflect the results of risk assessments of patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.

1.   The review will be approved by QCAC.
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PATIENT SAFETY/RISK MANAGEMENT PLAN
FY 2016
SIENA CAMPUS

PURPOSE

To establish system-wide guidelines and processes supporting a comprehensive, effective, organization-wide Patient Safety/Risk Management Program designed to promote and improve patient safety at Dignity Health - St. Rose Dominican Siena Campus, by preventing medical/healthcare adverse events and reducing risk to patients and visitors.

POLICY

The Patient Safety/Risk Management Program for Siena Campus includes campus specific collection and analysis of patient safety work products, Dignity Health Patient Safety Standards, Shared Learnings, Mistake Management Philosophy, integration with the Performance Improvement Plan and is approved by the Community Board, Medical Staff and Senior Leadership.   The program participates in the California Hospital Patient Safety Organization (CHPSO) to provide a coordinated and systematic campus specific approach to developing an information infrastructure and build better evidence-based improvement activities for patient safety, a critical component to reducing medical/healthcare events and improving the delivery of safe patient care .

Patient Safety Program and Performance Improvement

St. Rose Dominican - Siena Campus is committed to making the safety of all patients, employees, physicians and visitors a leadership priority for organizational performance improvement. The Patient Safety/Risk Management Program utilizes patient safety work products to encourage a culture of safety and provide feedback to each campus and assistance toward minimizing patient risk that includes processes to:

- Establish and maintain a culture of safety;
- Promote safety by collecting and analysis of patient safety work product to recognize and develop strategies to reduce risks and hazardous conditions that result in medical/healthcare events and patient injury;
- Support a strong internal non-punitive reporting mechanism;
- Facilitate the rapid redesign of unsafe care processes and systems in response to actual and potential adverse events;
- Support ongoing proactive efforts through implementation of known safe practices such as patient safety checklists and patient safety policies;
- Promote communication and coordination among individuals and departments to minimize risk to patients;
- Support notification of patients and when appropriate, their family, of unplanned outcomes;

- Utilize Dignity Health and SRDH data collection systems to monitor performance of new or revised processes including patient, family and staff input, needs, perceptions of risk to patients and suggestions for improvement.
- Support The Joint Commission (TJC) National Patient Safety Goals, Dignity Health Shared Learnings and other patient safety related initiatives such as IHI, etc. as proactive methods for risk reduction and patient safety initiatives.

Organizational Culture

An organizational culture has been established by the leaders of St. Rose Dominican Siena Campus that support the effective reduction of medical/healthcare events and other factors that contribute to unintended adverse patient outcomes. This culture is based on the principles of organization-wide cooperation and communication and encourages:

- The recognition and acknowledgement that preventing events and improving safety for patients requires a systems approach in order to modify the conditions that contribute to events;
- A focus on processes and systems including Infection Prevention; human factors; and education. Promotion of a just culture and minimization of individual blame or retribution for involvement in a medical/healthcare event;
- Internal sharing of trends/event evaluation and the actions taken to reduce risk
- Organizational learning about medical trends/best practices to affect the outcomes including unanticipated events.
- Participation in the CHPSO for enhancement of our activities to improve patient safety and the quality of health care delivered within the SRDH system

The organizational culture is also reflective of the Risk Mistake Management Philosophy, which supports the patient's right to be informed about the outcomes of their care, including unanticipated outcomes.

An effective Patient Safety/Risk Management Program cannot exist without optimal reporting of actual or potential medical/health care events and occurrences. Therefore, it is the intent of all Dignity Health - St. Rose Dominican hospitals to adopt a "just culture" approach in its management of events and occurrences. All personnel will report suspected or actual medical/healthcare event and may do so without fear of reprisal.

Scope of Activities

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 service.

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 undesirably 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 reactions
    - 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).
- NPSG audits to be completed at each campus by individual Departments utilizing a Performance Improvement Management System (PIMS) according to the Dignity Health audit criteria.

Leadership

The Dignity Health - St. Rose Dominican Community 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 defined, 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
- Annually evaluate the patient safety plan for its effectiveness in reducing risk and improving patient safety.
- Active participation in the California Hospital Patient Safety Organization (CHPSO)

Patient Safety Officer

The Director of Quality 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 include:

- Day to day responsibility for the Patient Safety 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

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 has oversight responsibility to ensure that the responsibilities and functions outlined in this program are carried forward throughout the organization. The following responsibilities are assigned:

- Serve as champions of the Patient Safety/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 Interdisciplinary Committee 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.

Physicians

Physicians are responsible, as participants in the patient safety 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 pain 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 those activities include:

- Active participation in the activities to improve patient safety and the quality of health care delivered.
- Adherence to Infection Prevention Measures; TJC National Patient Safety Goals and other patient safety initiatives.
- Participation in all 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 the information needs assessment, staff surveys and other processes that request information regarding the Patient Safety/Risk Management Program.
- Reporting all medication events (including near misses) even if they do not reach the patient in collaboration with the Pharmacy.
- Reporting all events and process variances (harm or no harm) even if they do not reach the patient (near misses).

PROGRAM

I. Proactive Risk Assessment Activities

A. The Risk Management/Patient Safety Department, in collaboration with the various facility Committees including Infection Prevention, Interdisciplinary 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:

1. An initial patient safety risk assessment evaluating known high risk processes/procedures that have associated risks;
2. Participation in an annual employee safety survey process in collaboration with Dignity Health, to include follow-up on areas not meeting goals;
3. On-going risk assessments based on internal and external data, including sentinel event alerts;
4. Focused risk assessments as determined by the Patient Safety Committee, Senior Leadership, external/internal events, etc.
5. Selection of patient safety process improvements and risk reduction activities utilizing the priorities set criteria of Siena campus.
6. Any information assessments conducted by St. Rose Dominican will include identification of barriers to effective communication among caregivers.
7. 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.
8. Infection Prevention Surveillance Program
9. 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.

B. Risk assessment activity results will be aggregated and analyzed. Appropriate department/process action plans will be developed in response to the results with the goal of reducing the actual, potential or perceived risk to patient safety.

II. Event Reporting

Siena actively participates in the CHPSO and its Patient Safety Evaluation System for data collection, monitoring, collaboration, and evaluations 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 the Regulation. (See Event Reporting and Management Policy.)

A. When an unplanned event/process variance occurs, the patient care provider will do the following:

1. Perform the necessary healthcare interventions to support the patient's clinical condition.
2. Perform the necessary interventions to contain the risks to others.
3. Notify the patient's attending physician.
4. 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.
5. Notify immediate supervisor of the event.
6. 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:

1. Individual's identifying such a condition will immediately report such to their supervisor, and document in the Event Report.
2. Take the necessary actions to ensure that any potential risks to patient care and safety are mitigated.

III. 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, Interdisciplinary and Environment of Care for analysis and action. Based on analysis of this data, 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:

1. Assessment of the intended and actual implementation of processes to identify the steps in where there is, or may be, undesirable variation.
2. Identification of the possible effects of the undesirable variations on patients and how serious the effect or outcome on the patient might be;
3. For critical effects/outcomes, a root cause analysis will be conducted to determine why the variation leading to the effect may occur;
4. Redesign of the process and/or underlying systems to minimize the risk of that variation or to protect patients from the effects of the variation;
5. Test and implement the redesign process;
6. Identification and collaboration with Quality Management Systems on implementation of measures of the effectiveness of the redesigned process; and

7. Implementation of a strategy for maintaining the effectiveness of the process over time.
8. Events that do not require a Root Cause Analysis will have a Performance Improvement Event Review (PIER) completed by the Quality/Risk Management as soon as practicable of becoming aware of the event. The results will be forwarded to Leadership for review.

IV. 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), PIER and/or a failure mode and effects analysis (FMEA), implement in action plan to reduce further risk to patients and establish measures of effectiveness as described above in Section III A.

    1. The following events always elicit an intense analysis:

        a. Confirmed transfusion reactions;
        b. Significant adverse drug reactions;
        c. Significant medication events and hazardous conditions;
        d. Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures; and
        e. Significant adverse events associated with anesthesia use.
        f. Hospital acquired infections
        g. All events meeting the definition of Sentinel Events in the State of Nevada.

    2. A root cause analysis is performed when a sentinel or State reportable event occurs.
    3. A PIER analysis 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.

    1. 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.
    2. Involved staff should be involved in the root cause analysis process.
    3. The Department Manager will provide on-going support to the staff member(s) as needed.

4. Whenever necessary, Crisis Intervention or Employee Assistance Programs (EAP) will be offered as support to the involved employee.

V. Education

A. Staff Education

1. General orientation, on-going in-service and other education and training programs will emphasize specific job-related aspects of patient safety and risk reduction strategies.
2. Specific Patient Safety/Risk Management Program training at orientation and annually thereafter will include:
    - An overview of the Patient Safety Program
    - Overview of the TJC National Patient Safety Goals
    - Staff's role and responsibilities in the Patient Safety/Risk Management Program
    - Event reporting criteria and process
    - 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.
3. 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

1. 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.
2. Specific physicians may receive additional training to support their involvement at a higher level in the Patient Safety/Risk Management Program.

VI. 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 stated including but not limited to medical staff, Interdisciplinary 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 Medical Executive Committee.

C.   Annually, the Patient Safety/Risk Management Program will be evaluated for effectiveness and the program updated to reflect the results of risk assessments of patients, families and staff. The review shall include a summary of the occurrence of medical/healthcare events and actions taken to improve patient safety, both in response to actual occurrences and proactive efforts.

   1. The review will be approved by QCAC.
   2. Will be submitted to the Community Board for final review and approval.

Revision Reviewed/Approved:
Patient Safety Committee, April 20, 2015
Quality Care Advisory Committee of the Board, May 8, 2015
Community Board, May 28, 2015

References:
NRS Chapter 439
California Hospital Patient Safety Organization
Infection Prevention Plan
Performance Improvement Plan

Patient Safety Plan

2015

Revised February 2015

OVERVIEW

Summerlin Hospital Medical Center (SHMC) Patient Safety Plan (PSP) serves as part of the UHS Acute Care Patient Safety Organization through promotion of a system-wide approach to managing, reducing and eliminating patient safety risk. UHS of Delaware utilizes a certified Patient Safety Organization (PSO) to improve patient safety and to maintain the confidentiality of patient safety communications (known as patient safety work product or "PSWP"). The PSO tracks patient safety information, provides direction and feedback on patient safety efforts in the Acute Care Division, and promotes the use of best practices. The PSO was created to further the Acute Care Division's longstanding commitment to promoting patient safety and assure that UHS affiliated facilities would remain at the forefront in the delivery of safe and effective clinical operations. This Plan, combined with the Corporate Quality Plan and the Risk Management Plan, comprise the global structure for Patient Safety in Summerlin Hospital Medical Center.

MISSION and VISION

The SHMC Patient Safety Plan supports the overall company mission of providing safe and efficient care to our community 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.

Mission: To provide exceptional quality patient care in a safe and compassionate environment that provides a positive healing experience for patients and their families.

Vision: To be recognized as a community health leader distinguished by our people, quality, service and dedication to patients and families. Our passion will be to deliver care in a patient and family centered manner:

- Every person
- Every time
- Every day
- Everywhere

Our care will be guided by the principals of respect, empathy, dignity and the emotional health and wellbeing of our patients.

Core Value
Patients and Families are our Purpose

GOALS and OBJECTIVES

SHMC is part of the UHS integrated, system-wide patient safety program designed to improve patient safety and reduce risk to patients. The UHS PSP provides the mechanism to continually assess and improve the patient safety systems within each organization to which it applies. It is also our strategy to use statistical tools and defined project work to achieve breakthrough gains in patient safety and profitability. Improvement strategies will utilize six sigma and other

performance improvement tools that focus on developing and delivering near perfect processes and services consistently. The SHMC program will provide for a non-punitive approach to identifying and reporting adverse events.   This is balanced with acceptance of the "Just Culture" concept. The purpose is 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 will be used. The goal is to identify and track errors in order to continuously improve those systems and to intervene as necessary to prevent recurrence. When specific acts of "at risk" or "reckless behavior" are identified with an event, individual accountability will be addressed. This could include disciplinary action.   SHMC employees, contractors, vendors, and members of the medical staff share responsibility to participate in detection, reporting, and remediation to prevent errors.

Our Goals are to:

- Establish a hospital-wide patient safety oriented culture.
- Implement interdisciplinary education/training of patient safety standards, patient safety checklists, program/plan and individual accountability.
- Improve patient safety though on-going proactive assessment and use of tools such as root cause analysis and failure mode and effects analysis (FMEA).
- Implement immediate response processes to sentinel events.
- Implement response and processes to unanticipated/unexpected events.
- Assess the resource allocations for patient safety
- Analyze safety event data to achieve reduction in events/errors or injury.
- Establish a reporting system that promotes and supports non-punitive actions

SCOPE

This Patient Safety Plan applies to Summerlin Hospital Medical Center as part of UHS of Delaware Acute Care Division. The Plan encompasses all departments and services including those services provided via contracted sources. This plan is an individualized Patient Safety Plan that is congruent with the UHS PSP and tailored to meet jurisdictional requirements.

AUTHORITY AND RESPONSIBILITY

The President of UHS and the President of the Acute Care Division have the authority, accountability and responsibility for assuring that adequate resources, support and leadership are allocated to implement this Patient Safety Plan. The UHS Leadership Team delegates the authority for the implementation and oversight of this Plan to the Corporate Patient Safety Council. The facility Patient Safety Council is accountable to the hospital Governing Body to ensure patient safety improvement occurs on an ongoing basis through this and related plans.

This plan is developed, implemented, coordinated and directed by the Summerlin Hospital

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Summerlin Hospital Medical Center Patient Safety Plan

Medical Center Patient Safety Officer and the Patient Safety Council. The Patient Safety Council is an interdisciplinary committee comprised of medical staff leaders, administration, nursing, risk management, quality management, pharmacy and infection control. Ad Hoc departments are asked to participate as necessary. The Patient Safety Council functions in collaboration with other hospital and medical staff committees, such as but not limited to; Environment of Care Committee, Pharmacy and Infection Control Committee, Hospital Performance Improvement Committee, and the Medical Executive Committee.

Chair of the Patient Safety Council will be the Patient Safety Officer.
The Patient Safety Council functions as a sub-committee of the Performance Improvement Committee and reports directly to the Medical Executive Committee and to the Governing Board.

PATIENT SAFETY EVALUTION SYSTEM

The Patient Safety Evaluation System (PSES) includes all programs, systems and processes designed to improve patient safety. The PSES serves as the means by which patient safety information is collected, maintained and analyzed for the reporting to Summerlin Hospital Medical Center and UHS PSO for the purposes of improving patient safety. The PSES allows for PSWP to flow directly between the PSO and member facilities.

UHS PATIENT SAFETY ORGANIZATION

As a listed PSO, the UHS Acute Care Patient Safety Organization has as its primary mission the assessment and improvement of patient safety systems within its member facilities. The PSO receives PSWP and provides analysis and recommendations to its member facilities. The main vehicles for these activities include the Corporate Patient Safety Council and the member facility Patient Safety Councils. The UHS PSO uses a secure SharePoint site to maintain and manage PSWP.

PATIENT SAFETY COUNCIL

The Patient Safety Council, (PSC) is a central component of the UHS and acute care facility PSES. Each facility PSC consists of five core members including: the Chief Executive Officer, the Chief Nurse Executive, the Chief of Staff, the Quality Manager, and the Risk Manager. The PSC is charged with the assessment and improvement of processes related to patient safety. In addition, the PSC is the method by which facility PSWP is communicated to the UHS PSO.

Each facility PSC receives analyzed PSWP from the UHS PSO and acts to resolve identified concerns or implements best practice recommendations. Additional topics addressed by the PSC include: patient safety survey reports, Patient Safety Advisories, TJC Sentinel Event Alerts, issues derived from event analysis, UHS patient safety dashboard implications, and other patient safety-related topics. All information and data related to the activities of the PSC are confidential and protected from discovery under the authority of the Patient Safety and Quality Improvement Act of 2005. Additional protections may be available based on a facility's jurisdiction.

REPORTING OF PATIENT SAFETY EVENTS

A key factor in the improvement of patient safety systems is the ability to collect information about adverse events. Staff and physicians must be free to communicate concerns about safety and actual events without the fear of reprisal. Summerlin Hospital Medical Center promotes a Just Culture and a non-punitive approach to incident reporting. The goal is to identify and track events to continuously improve patient safety systems. All adverse events will be reported immediately to the PSES. Any team member knowingly fails to report a medical error or omission may be subject to disciplinary action.

Root Cause Analysis (RCA) should be applied to all serious adverse events and those near misses that had the potential to be a sentinel event. An RCA should be completed within 30 days of the date of the event. All documents related to the RCA and the RCA itself are considered Patient Safety Work Product and should be routed through the facility Patient Safety Council and ultimately to the UHS PSO. Failure Mode and Effects Analysis (FMEA) is a proactive tool used to identify and minimize patient safety risks. Like the RCA, the FMEA and documents associated with the FMEA are PSWP and privileged and confidential.

All departments within the organization (clinical and support) are responsible to report any patient

safety events, and potential events by the completion of incident report. This report is then routed to Risk Management. Risk Management screens reports for potential sentinel events or unexpected events/outcomes. Risk Management will communicate on an on-going basis with the Patient Safety Officer/Council regarding clinical events, and/or trends such as patient falls, medication errors, treatment error or unexpected outcomes.

Risk Management will provide data, data analysis of events to the Patient Safety Council on a systematic basis.

Opportunities, patterns or trends will be identified and actions taken for improvement in interdisciplinary committees.

ANALYSIS AND IMPROVEMENT

Improvement activities are prioritized according to set criteria, that includes: compliance related to accrediting standards or error prone or high risk processes, mission/vision/values, strategic/operational goals and cost/benefit analysis. The priorities will be determined in an interdisciplinary committee setting such as Patient Safety Council, Hospital Performance Improvement Committee, Medical Executive Committee and/or the Governing Board.

The PSP recommends the use of a four-step methodology for the assessment and improvement of patient safety issues.

- **Issue Identification**: Issues are identified through various means including: surveys, incident trends, patient safety assessments, event analysis, patient safety advisories, sentinel event alerts and other mechanisms.

- **Best Practice**: Once identified, issues should be analyzed to determine root cause and best practice. Best practice is determined based on industry standards and should be evidence-based.

- **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, process changes, etc. Responsible parties and dates for completion are identified to ensure success.

- **Monitoring and Accountability**: Accountability requires a continuous process of setting expectations, monitoring performance, reporting on outcomes, and making improvements in patient safety programs that are sustained over time.

SECURITY

All PSWP will be kept separate from the rest of the parent company. This separation will consist of a segregated electronic site (SharePoint) and all components of the PSES that is accessed only by

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authorized PSO members. Electronic and hard copy systems retaining PSWP must be secured and maintained by PSO staff or authorized member facility staff.

EDUCATION

Annual education of affected staff will be conducted to ensure structure and intent of the Patient Safety Plan is ingrained in the organization. Staff will receive education and training during their orientation and on an on-going basis regarding job specific aspects of patient safety, including the need to report medical/health events. The education of the staff will be interdisciplinary teamwork as the delivery of patient care is interdisciplinary

ANNUAL EVALUATION

The Summerlin Hospital Medical Center Patient Safety Council annually reviews the effectiveness of the Patient Safety Plan to ensure activities are appropriately focused on improving patient safety at the facility.

References:

- *UHS Technical Elements of Risk Management (TERM) program*
- *UHS Risk Management Plan*
- *UHS Quality Management Plan*
- *World Health Organization, WHO Draft Guidelines for Adverse Event Reporting and Learning Systems*
- *Patient Safety and Quality Improvement Act of 2005*
- *Summerlin Hospital Medical Center Event Reporting and Midas Remote Data Entry policy*
- *Summerlin Hospital Medical Center Sentinel Event policy*

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Appendix A: Definitions

Adverse Event
An injury related to medical management, in contrast to complication of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or non-preventable.

Corporate Patient Safety Council
Primary vehicle for review, discussion and action on PSWP information. Membership includes, Chief Information Officer, Chief Nursing Officer, Staff Vice President Insurance, Vice President Operations, Vice President Quality Management, Vice President Human Resources Corporate Director Risk Management, Corporate Director of Pharmacy, Chief Information Officer.

Error
The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors may be errors of commission or omission, and usually reflect deficiencies in the systems of care.

Event Notification System (ENS)
Event Notification System is part of the PSO SharePoint site and functions as a communication tool to PSO stakeholders relative to Sentinel/Serious/Near Miss events occurring in the division.

Facility Patient Safety Council
Primary group for all acute care division hospitals responsible for review, discussion and action on PSWP information. This group is accountable for validation of successful correction of identified patient safety issues and communication of that process to the facility Board of Governors and quality oversight Committees as appropriate.

MIDAS
Electronic incident reporting system used at all acute care division facilities to report identified events related to patient safety and a key component of the PSES.

Near Miss
Serious error or mishap that has the potential to cause an adverse event but fails to do so because of chance or because it is intercepted. May also be referred to as a potential adverse event.

Patient Safety Evaluation System (PSES)
Information management, communication system, and analysis system for all programs and processes designed to improve patient safety. PSES encompasses both Corporate UHS of Delaware and all facilities operating in the Acute Care Division of UHS of Delaware. This

includes, but is not limited to information associated with patient safety surveys, MIDAS events, STARS submissions, trended MIDAS/STARS data, Corporate PSC work product, patient safety/risk advisories communications, patient safety team meetings at any facility in the acute care division (falls teams, medication safety teams, incident review teams), FMEA and RCA work products. This system includes any prefacing communication that is used to communicate between the Corporate PSO entity and the respective facility PSO members and communications within the facility that may or may not be forwarded to UHS Corporate.

Patient Safety Work Product (PSWP)
Data, reports, memoranda, analyses, deliberations or written or oral statements that are assembled or developed with the intent of reporting to a PSO or are developed by a PSO for conduct of patient safety activities. Includes but is not limited to the following: MIDAS entries, ENS entries, STARS submissions, Patient Safety Survey results and action plans, communications between facility PSC and PSO staff, investigation and analysis of adverse events.   See Appendix B, PSWP Inventory List

Patient Safety Surveys:
Site surveys performed by members of the Corporate PSO or others. Results of survey are communicated as PSWP to the facility PSC where a corrective action plan is generated and monitored through that committee to successful conclusion. Progress is periodically reported via the monthly PSC report to the Corporate PSC.

SharePoint
Secured, electronic, web-based repository for PSWP. Access to site is secured and available only to members of the PSO.

STARS
Electronic serious event reporting technology used only by facility and corporate PSO members.

2/17/2014

Appendix B: Patient Safety Work Product Inventory (This inventory is not intended to be all inclusive)

PSWP Produced by the UHS Acute Care PSO

- Analysis and Commentary on Action Plans
- Analysis of Facility PSC Reports
- Analysis of Facility RCAs
- Event Analysis and Recommendations
- Patient Safety Communications between PSO Staff and Member Facility Staff
- Patient Safety Dashboard
- Survey reports

PSWP Published to All Member Facilities

- Patient Safety Advisories
- Patient Safety Communications
- Risk Advisories and Alerts

Member Facility PSWP

- Accreditation/Certification Work
  - Bariatric
  - Chest Pain
  - Stroke
  - TJC
  - Trauma
- Committee Minutes Reflecting Patient Safety Deliberations
  - Environment of Care
  - Ethics
  - Failure Mode and Effects Analysis
  - Fall Prevention
  - Grievance
  - Infection Prevention
  - Lean Six Sigma
  - Medical Staff
  - Medication Safety
  - Performance Improvement Teams
  - Product Safety
  - Quality Oversight
  - Root Cause Analysis
- ENS Discussion Board Submissions
- ENS Submissions
- Event Reports (only portions of the incident report are considered PSWP)
- Failure Mode and Effects Analyses

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- NPSG Work Product
- Patient Safety Communications
- Patient Safety Council Reports
- Potential Claim Report (PCR) Submission and Analysis (only portions of the PCR are considered PSWP)
- Root Cause Analyses
- Safety Surveillance Rounds
- Survey Action Plans
- Peer Review
    - Nurse
    - Physician

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PURPOSE

Sunrise Hospital and Medical Center and Sunrise Children's Hospital develops, implements, and maintains an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.

STRUCTURE

Sunrise Hospital and Medical Center and Sunrise Children's Hospital has a leadership structure to support operations and the provision of care. The structure is formed by three leadership groups: the Board of Trustees (BOT), the organized medical staff which is represented by the Medical Executive Committee (MEC), and Senior Leadership.

A. Board of Trustees (BOT)
    The Board of Trustees serves as the governing body legally responsible for the conduct of the hospital as an institution. The BOT has ultimate responsibility for safety and quality which is derived from their legal responsibility and operational authority for hospital performance. In this context, the BOT provides for internal structures and resources, including staff that supports safety and quality. Working with the Medical Executive Committee and Senior Leaders, the BOT establishes a mission, vision, and goals of the organization to support safety, quality of care, treatment, and services.

    The roles and responsibilities of the BOT in ensuring performance improvement and patient safety activities include:
    1. Reflects the complexity of the hospital's organization and services; involves all hospital 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 the hospital's written scope of services.
    6. Selects and approves the Chief Executive Officer (CEO) responsible for managing the hospital.
    7. Works with the Senior Leaders and the MEC to annually evaluate the hospital's performance in relation to its mission, vision, and goals.
    8. Ensures the ongoing program for quality improvement 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 the hospital and medical staff.
    12. Establishes a process for making decisions when a leadership group fails to fulfill its responsibilities and/or accountabilities.
    13. Provides for the resources needed to maintain safe, quality care, treatment, and services.
    14. Provides a system for resolving conflict among individuals working within the organization.

15. Receives and reviews reports summarizing the data, analysis, findings, and recommendations related to hospital-wide organizational performance improvement projects and Clinical Safety Improvement Program (CSIP).
16. Reviews the annual Performance Improvement (PI) and Clinical Safety Improvement Program Appraisal of the PI activities.
17. Approves the annual Performance Improvement and Patient Safety Plan.

B. Medical Staff and Medical Executive Committee (MEC)
Sunrise Hospital and Medical Center and Sunrise Children's Hospital has an organized medical staff that is accountable to the BOT. The medical staff is represented by the Medical Executive Committee (MEC).

The role and responsibilities of the MEC in ensuring performance improvement and patient safety activities include:
1. Organized and accountable to the BOT for the quality 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 Performance Improvement and Patient Safety Plan including the design of performance improvement 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 the hospital's 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.

C. Senior Leaders
Sunrise Hospital and Medical Center and Sunrise Children's Hospital identifies the responsibilities of its Senior Leaders.

The role and responsibilities of Senior Leaders in ensuring performance improvement and patient safety activities include:
1. A Chief Executive Officer (CEO) manages the hospital 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. The Chief Executive Officer (CEO), MEC, the Chief Nurse Officer (CNO), and the Vice-President of Quality work together to make certain that the hospital-wide performance improvement and Clinical Safety Improvement Program along with training programs address identified problems.
4. Discuss issues that affect the hospital and the population(s) it serves, including the following:
   a) Performance improvement and Clinical Safety Improvement activities.
   b) Reported safety and quality issues.
   c) Proposed solutions and their impact on the hospital's 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 or 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 repose to sentinel events. See #ORG2485 Sentinel Event Policy.
8. Selects one high-risk process and conducts a proactive risk assessment at least every 18 months.

9. Creates and maintains a culture of safety and quality throughout the organization. The organization regularly evaluates the internal culture of safety and quality using the Agency for Healthcare Research & Quality (AHRQ) Hospital Survey on Patient Safety Culture. The survey allows Leaders to:
   a) Prioritize and implement changes identified by the survey.
   b) Provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives.
   c) Develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
   d) Create and implement a process for managing behaviors that undermine a culture of safety.
   e) Provide education that focuses on safety and quality for all individuals.

D. Patient Safety Officer (NRS 439.870)
   The organization has designated the Risk Manager as the Patient Safety Officer for the organization. The Patient Safety Officer
   1. Serves on the Quality Care and Patient Safety Committees.
   2. Promotes a culture of safety and the elimination of avoidable harm.
   3. Supervises the reporting of all sentinel events. Also see #ORG2485 Sentinel Event Policy.
   4. Takes action as deemed to be necessary to ensure the safety of patients as a result of an investigation of the event.
   5. Reports all sentinel events and the actions taken to ensure the event does not reoccur.

E. Department Directors
   The Department Directors of each ancillary/nursing service area is responsible for all Performance Improvement and Patient Safety activities as they relate to their specific areas. The 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. The Directors are responsible for evaluating the effectiveness of care delivered in their departments and the clinical performance of their staff. Although it is recognized that process issues or deficiencies account for most variances in performance, when performance improvement 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. Significant findings of Performance Improvement or Patient Safety activities will be reported through the appropriate channels.

F. Patient Safety Committee (PSC) and Quality Care Committee (QCC)
   The Patient Safety Committee receives reports from the Quality Care Committee and is responsible to the BOT, MEC, and Senior Leaders for the overall operation of the Performance Improvement and Patient Safety Plan. This is an interdisciplinary committee that includes but is not limited to, representatives from the BOT, Senior Leaders, Medical Staff, Quality Management, Pharmacy, Nursing Leadership, Infection Control, Ancillary Services Directors, and Patient Safety Officer and Facility Safety Officer. On an annual basis the QCC performs an annual Performance Improvement (PI) Appraisal of the PI activities. At this meeting, current performance improvement priorities, patient safety priorities, and associated activities are reviewed and evaluated.

   General functions of the Patient Safety and Quality Care Committee include:
   1. Collects data to monitor its performance. The BOT, MEC, and Senior Leaders set priorities for and determine the frequency of data collection.
   2. Measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations.
   3. Collects data and reports to the QCC, MEC, and BOT. The types of data collected includes but is not limited to:

      a) Operative or other procedures that place patients at risk of disability or death.
      b) All significant discrepancies between preoperative and postoperative diagnoses, including

pathologic diagnoses.
c) Adverse events related to using moderate or deep sedation or anesthesia.
d) Use of blood and blood components.
e) All reported and confirmed transfusion reactions.
f) Results of resuscitation.
g) Behavior management and treatment.
h) Significant medication errors.
i) Significant adverse drug reactions.
j) The hospital considers collecting data on the following:
     i. Staff opinions and needs
     ii. Staff perceptions of risk to individuals
     iii. Staff suggestions for improving patient safety
     iv. Staff willingness to report adverse events
l) Patient perception of the safety and quality of care, treatment, and services.
k) Evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.
l) Effectiveness of its response to change or deterioration in a patient's condition. 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.

4. The PSC shall have oversight of: the Hospital Patient Safety Program, which includes but is not limited to:
a) Review the annual Patient Safety Plan and Strategies.
b) Collect data to monitor Patient Safety Plan performance. Measure, analyze, and track safety indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations. The types of data collected includes but is not limited to:
     a. Patient safety related to the use of at least two 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's), Central Line Associated Bloodstream Infections (CLABSI's), Surgical Site Infections (SSI's), and other hospital acquired infections.
     c. Safe surgical practices by prevention of mistakes made in surgery such as wrong patient, wrong site, and wrong procedure with utilization 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 hospital acquired conditions (HAC) to improve health outcomes and reduce length of stay.
c) Receive reports from the patient safety officer pursuant to NRS. 439.870
d) Review and evaluate the quality of measures carried out by the medical facility to reduce the number of severity of sentinel events and infection that occur at the medical facility.
e) Ensures all Patient Safety policies/checklists follow protocols to improve the health outcomes of patients at the medical facility and will include, without limitation:
     i. Policies/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.
     ii. Policies/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.
     iii. Policy/checklist to be used when discharging a patient from the facility which includes,

without limitation, verifying that the patient received:

    iv. Policy/checklist to be used for providing proper instructions concerning prescription medications;

    v. Instructions concerning aftercare; and any other instructions concerning his or her care upon discharge.

f) Ensure that a policy for appropriately identifying a patient before providing treatment is in place, the policy will require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include without limitation, the name and date of birth of the patient.

g) 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 is in place and evaluated.

h) Monitor and document the effectiveness of the patient identification policy.

i) At least annually, review the patient safety checklists and patient safety policies adopted and consider any addition patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.

j) Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.

k) 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. 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 (2)

l) Evaluate the recommendations provided to the executive or governing body of the medical facility regarding:

    i. The number of sentinel events that occurred at the medical facility 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.

m) 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.

5. The QCC compiles and analyzes data:
   The program includes, is but 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:

   a) Sets expectations for using data and information to improve the safety and quality of care, treatment, and services.

   b) Responsible for the implementation of successful corrective action plans in affected problem areas.

   c) Measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations.

   d) Develops, implements, and maintains an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.

   e) .

   f) Compiles data in usable formats.

   g) Uses statistical tools and techniques to analyze and display data.

   h) Analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

   i) Compares data with external sources, when available.

    j) Analyzes its organ procurement conversion rate data as provided by the organ procurement organization (OPO).

    k) Uses the results of data analysis to identify improvement opportunities.

    l) In regard to staffing:

        i. When the hospital 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.

        ii. When analysis reveals a problem with the adequacy of staffing, the Senior Leaders are responsible for the hospital-wide patient safety program are informed, in a manner determined by the safety program, of the results of this analysis and actions taken to resolve the identified problem(s).

        iii. At least once a year, the leaders responsible for the hospital-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.

    m) The QCC considers participation in Quality Improvement Organization (QIO) cooperative projects.

    n) The Trauma Program manages an intensive Performance Improvement and Patient Safety (PIPS) program regarding its practice. Minutes of the Program's reviews are submitted to the MEC and the BOT through the Department of Surgery. In addition, members of the hospital Quality Assurance Program attend the Trauma Peer Review Committee meetings.

6. The PSC and QCC ensures the organization improves performance on an ongoing basis, including:

    a) Prioritizes the identified improvement.

    b) Takes action on improvement priorities.

    c) Evaluates actions to confirm that they resulted in improvements.

    d) Takes action when it does not achieve or sustain planned improvements.

7. The PSC and QCC drafts priorities for the organization's performance improvement activities, which are recommended for adoption through the Medical Executive Committee and the Board of Trustees. QCC considers factors such as:

    a) Focus on high-risk, high-volume, or problem-prone areas,

    b) Consider the incidence, prevalence, and severity of problems in those areas.

    c) Affect health outcomes, patient safety, and quality of care.

PATIENT SAFETY ORGANIZATION

Sunrise Hospital & Medical Center, Sunrise Children's 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.

METHODOLOGY

FOCUS-PDCA is the methodology used for performance improvement projects. Using this methodology data are systematically aggregated and analyzed on an ongoing basis. Statistical tools used are displayed in diagram 2 below.

A. FOCUS

    1. Find an improvement opportunity:
       a) Review results of measurement activities and input from staff, patients, physicians 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?

    2. 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.

    3. 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? Review recent scientific literature for up to date information regarding the process.

    4. 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?

    5. 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?

B. PDCA
    1. 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 tract the process change?
       c) Identify those forces that assist or prevent change-force field analysis.

2. <u>Do improvement:</u>
   a) <u>Implement change</u>

3. <u>Check results:</u>
   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?

4. <u>Act</u> (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.

<u>Serious Event Analysis</u> is the primary Performance Improvement methodology utilized for analysis of significant unanticipated outcomes and/or Sentinel Events. See #ORG2485 Sentinel Event Policy.

EXTERNAL DATA SOURCES

Data is also collected as indicated for participation in the following external databases or for participation with the following organizations:

<u>Health Insight</u>
The CMS contracted Quality Improvement Organization (QIO) has developed Healthcare Quality Improvement Initiatives that examine patterns of practice. Areas for study are suggested by practitioners in the community, university, hospital settings, nationally recognized patient safety and quality improvement organizations and CMS. Studies enable hospitals and physicians to compare their performance with what may be optimal levels of practice.

<u>CHOIS Reports</u>
Comprehensive Health Outcomes Information System is designed to identify opportunities for improvement, identify best practices, and manage resources appropriately, effectively, and efficiently. Clinical Outcome Summary Reports are distributed on a quarterly basis. The data captured in this report reflects numerous clinical indicators. These indicators were developed through physician focus groups. The data is risk and severity adjusted using CMS's Refined DRGs and ECRI, a risk index used to adjust complication rates, RAMI, Risk Adjusted Mortality Index and RASPEC, the risk adjustment specialty algorithm as appropriate. Each hospital is provided with actual and risk adjusted mortality and complication rates. Rates are compared to the company overall and national statistics. Patient and physician level details are provided to facilitate a detailed analysis of the cases reflected in the data.

<u>ORYX / Joint Commission Measurement System</u>
This is the Joint Commission initiative to integrate performance measures into the accreditation process. It involves a collection of service, process and outcome indicators related to specific patient populations. Measures selected include Acute Myocardial Infarction, Heart Failure, Surgical Care Improvement Project (SCIP), Outpatient Perspective Payment System (OPPS), and Pneumonia. Data for this initiative is collected through the COMET (Comprehensive Outcomes Measurement Evaluation and Transmission) database. The information is collected at the facility level and transmitted directly to the Joint Commission from HCA, as the chosen vendor for this project.
Data abstracted through the COMET system are also submitted to CMS for public reporting through the Hospital Compare website. The Hospital Compare website was created through the efforts of the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (DHHS), along with the Hospital Quality Alliance (HQA). The HQA is a public-private collaboration established to promote reporting on hospital quality of care. The HQA consists of

organizations that represent consumers, hospitals, doctors and nurses, employers, accrediting organizations, and Federal agencies. The information on this website can be used by any adult needing hospital care.

HCAHPS
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a national, standardized, publicly reported survey of patients' perspectives of hospital care.

Vermont Oxford Neonatal Database
Oxford Neonatal Database is a comprehensive database of 600+ neonatal intensive care centers which compares morbidity, mortality, and length of stay data on the very low birth weight infants (501-1500 Gms). 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
The Cancer Registry submits cancer data on select neoplasms to the State of Nevada per NAC 457.010 – 457.040. This data is generally requested annually. The Cancer Registry department manages the cancer program and the American College of Surgeon's Commission on Cancer accreditation. The accreditation program maintains a robust set of metrics pertaining to 37 standards for the diagnosis, treatment and follow-up of cancers. As part of the accreditation, the Cancer Registry collects data adhering to the CoC's strict criteria and submits data to the Nation Cancer Data Base (NCDB). Data is submitted to the NCDB at schedule intervals. NCDB data is used nationally to identify areas for quality improvement as well as direct other important activities. The 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 Quality Improvement Program data reports. The CoC used NCDB data to direct participating organizations to perform special studies throughout the year.

Trauma Registry
Trauma Registry at Sunrise is a State of Nevada database. The Nevada Trauma Registry (NTR) data are collected from all licensed acute care hospitals and trauma centers in Nevada. The NTR can provide information on the incidence, and prevalence, morbidity, and mortality of injuries in Nevada. The data can be broken down to a specific county, specific hospital, specific race, or specific age group, for example. These 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.

The Society of Thoracic Surgeons (STS)
Offers outcome programs in the areas of Adult Cardiac, General Thoracic and Congenital surgery. 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. Sunrise hospital participates in the STS database, utilizing the national comparisons and benchmarking as an integral part of the PI program for Cardiovascular Services.

ACC/NCDR Registry
National Cardiovascular Data Registry is the recognized resource for measuring and quantifying outcomes and identifying gaps in the delivery of quality cardiovascular patient care in the United States. 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
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

Emergency Management Risk Initiative audit is one of the fundamental elements in the creation of the risk managed emergency department. This is the most powerful audit tool available in emergency medicine. It is clinically oriented and provides an unprecedented look at the individual practitioner, the emergency practitioners as a group, and emergency department systems. This audit is accomplished through the Sullivan Group via an agreement with HCA hospitals. Sunrise participates on a semi-annual basis.

Get With The Guidelines

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. This 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.

Leapfrog

The Leapfrog Hospital Survey is the public reporting initiative launched in 2001 by the Leapfrog Group. The 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. Leapfrog strives to make giant "leaps" forward in safety, quality, and affordability of healthcare by promoting transparency.

The Leapfrog Group Survey assesses hospital performance based on 28 different metrics. The Leapfrog algorithm computes a letter grade reflecting the hospital's performance based on these metrics. Currently 9 different Safe Practices are assessed. These safe practices, created by the National Quality Forum (NQF), have been found to reduce preventable medical mistakes. Leapfrog works to continually assess safe practices and new practices are added or removed accordingly. The Leapfrog algorithm also analyzes 18 data points from the publically reported data as required by the Centers for Medicare & Medicaid (CMS).

National Healthcare Safety Network (NHSN) Database

The NHSN is a secure, internet-based surveillance system that integrates former CDC surveillance systems, including the National Nosocomial Infections Surveillance System (NNIS), National Surveillance System for Healthcare Workers (NaSH), and the Dialysis Surveillance Network (DSN). NHSN enables healthcare facilities to collect and use data about healthcare-associated infections, adherence to clinical practices known to prevent healthcare-associated 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

Infection Control

Pharmacy and Therapeutics

Medication Usage

Blood Usage

Information Management

Information Services

Medical Records

Provision of Care, Treatment and Services

Hospital Depts/ Functions

Safety/Mgnt. of the Environment of Care

Medical Staff Department Committees

Utilization/Resource Management/ Continuum of Care

Trauma PIPS

Quality Care Committee

Patient Safety Committee

Performance Improvement Teams

Medical Executive Committee

Board of Trustees

Diagram 1

FOCUS - PDCA

Find Process Improvement Opportunity → Brainstorming
Control Charts
Comparison charts

Organize A Team That Knows The Process → Brainstorming

Clarify Current Knowledge of the Process → Flow Chart
Brainstorming
Cause and Effect Diagram
Literature Search

Uncover Root Causes Of Process Variations → Cause and Effect Diagram
Pareto Chart
Brainstorming
Failure Mode & Barrier Analysis

1. Start

PDCA Improvement

Brainstorming
Cause & Effect
Diagram

Brainstorming
Checklist
Cause and Effect
Diagram
Force Field Analysis

ACT   PLAN

CHECK   DO

Pareto Charts
Run Charts
Control Charts

Checklist
Implementation
Guidelines

Title:	Patient Safety Program	Policy #:	051-37-026.1
Effective Date:	January 2004	Department: Category:	Quality Mgmt Performance Improvement
Revision Date(s)	January 2004, March 2012	Changeability:	☐ Fixed ☒ General

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

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.

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 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.

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. The LifeCare policy, National Patient Safety Goals contains the policy and procedure detailing 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

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.
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    c. Discharge checklist
    d. Respiratory Treatment competencies

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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

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
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4. Patient Satisfaction reports
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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 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.

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   d. Healthcare Reports
   e. Regulatory Reports
   f. Patient/Family Members

2. Continually improve processes of care delivery based on data analysis.
3. Develop policies and procedures that result from process improvement activities.
4. Develop and approve Patient Safety Education for the medical and hospital staff.
5. Conduct an annual risk assessment of patient safety issues/strategies from internal and external reports.

The Hospitals believe in a non-punitive reporting environment in order to maximize reporting of near misses, adverse outcomes, and sentinel events as it has been demonstrated that many errors are directly related to system and process failures. Disciplinary action may be considered when an involved individual takes action to hide the incident, is malicious or untruthful in reporting, when facts and circumstances suggest that the error was deliberate or in reckless disregard to patient and staff safety, or when the individual consistently fails in the detection, reporting or remedies to prevent mistakes. Reporting of patient safety issues to an outside agency will be done when required by regulation or as determined by the Administrator.

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.

Title:	Patient Safety Program	Policy #:	051-37-026.1	
Effective Date:	January 2004	Department: Category:	Quality Mgmt Performance Improvement	
Revision Date(s)	January 2004, March 2012	Changeability:	☐ Fixed ☒ General	

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

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
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Methodology

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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.

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UNIVERSITY MEDICAL CENTER
PATIENT SAFETY PROGRAM
MANAGEMENT PLAN 2016

I.   PURPOSE

The purpose of the UMC Patient Safety program is to provide an organization-wide systematic, coordinated, and continuous approach to improve and maintain patient safety.

This is achieved through:
- Promoting a culture of safety
- Recognition and acknowledgement of risks to patient safety and medical/health care errors
- Initiation of actions to reduce risks
- Internal and external reporting of what has been found and the actions taken
- Focus on processes and systems
- Support sharing of knowledge to effect behavioral changes in itself and other health care organizations

The leaders of University Medical Center foster patient safety by providing the motivation, mission, and resources. The Board of Trustees of University Medical Center has the ultimate responsibility for performance improvement and patient safety activity.

II.   SCOPE OF ACTIVITIES

The scope of the Patient Safety Program includes ongoing assessment using internal and external data and collective knowledge to prevent error occurrence and to correct patient safety concerns. The program encompasses the patient population, their families, clinical and medical staff, and UMC employees.

This is accomplished through:

- Patient safety occurrence information from aggregated data and event reports
- One Failure Mode Effect Analysis (FMEA) completed each year
- Employee health programming
- Interdepartmental collaboration

VI.   REPORTING OF PATIENT SAFETY EVENTS
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A. **Regulatory Requirements**

The organization will follow all statutory, regulatory and licensing agency reporting guidelines, and University Medical Center's policies.
NRS 439.835 mandates that:
- Within 24 hours after becoming aware of a sentinel event, an employee of the medical facility will notify the Patient Safety Officer of the event.
- Within 13 days after receiving notification, the patient safety officer shall report the date, the time and a brief description of the sentinel event to The Health Division.
- 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 date, time and brief description of the sentinel event to The Health Division within 13 days after becoming aware of the sentinel event.

- Within 45 days after receiving notification or becoming aware of the sentinel event, the patient safety officer of the medical facility in which the sentinel event occurred must submit a second report to The Health Division.

NRS 439.870 mandates that:
- A medical facility shall designate an employee of the facility to serve as the patient safety officer.
- The Patient Safety Officer will report events as defined by the State of Nevada.

B. Incident Reporting

All medical, nursing and support clinical staff are required to report any event, situation or circumstance that is significant or potentially significant to patient safety. These events will be reviewed and investigated as needed.

This is accomplished by:
- Completing an event report in accordance with UMC policy
- Area manager review and completion of the manager's section of the event report
- Quality review by the Center for Quality and Patient Safety
- Review of significant/potentially significant events by the Patient Safety Officer
- Unit review of event types with action plan delivered at the Patient Safety Council

C. Proactive Risk Assessment

The goal of proactive risk assessment is to identify and to implement strategies to prevent and minimize adverse events.

A proactive risk assessment is done but not limited to new technology initiatives, low volume cases and any high risk patient population. The risk assessment includes (but is not limited to):
- The annual FMEA
- Evaluation of low harm Safety Intelligence scores for trends
- Review of ODA shift reports and expiration log
- Root Cause Analysis with action planning
- Participation in departmental activities supporting patient and environment of care safety
- Participation in regulatory compliance activities
- Verbalized concerns from leadership, staff, and medical staff

D. Disclosure of event to patient/family

In most instances, 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 will disclose the event to the patient/family. The physician or his/her designee should communicate:

- acknowledgement of the event
- event information known to date
- that a full analysis will take place
- what is currently taking place as a result of the event
- additional information on an ongoing basis

- measures taken to prevent recurrence
- apology that an event occurred

E. Support for the family, patient, and caregiver

When an event has occurred with significant consequences for the patient, appropriate support from within the hospital will be mobilized in a coordinated fashion to assist the patient, family, and caregiver. Support may include Pastoral Care, Social Work, or Employee Assistance Program and the involvement of the health care team.

VII.   DATA COLLECTION AND RISK ASSESSMENT

Data Sources to Identify High Risk Processes include but are not limited to:
Internal:
Datix/Safety Intelligence (previously Patient Safety Net)
Medication Use, Drug use Evaluations, and Adverse Drug Events
Patient and Family Complaints
Risk Management and Safety findings
Compliance findings
Infection Control information
Operative/Procedural data
Blood Usage
Restraint Reviews
Resuscitation Effectiveness
Morbidity/Mortality Review findings
Departmental/Service indicators
Performance improvement and special study findings
Staff verbal reporting

External:
Joint Commission Sentinel Event Alerts
Joint Commission Core Measure Indicators
National Database of Nursing Quality Indicators (NDNQI)/UHC Nursing Quality Data Base
Professional Liability Carrier recommendations and alerts
UHC Clinical Database / Resource Manager
American Hospital Association/Nevada Hospital Association
State Board of Nursing and Nevada State Medical Board of Medical Examiners
Performance Improvement Registered Databases
HealthInsight
Patient Experience - HCAHPS
Culture of Safety survey
Nurse and physician satisfaction surveys
ISMP
IHI
NQF / AHRQ
National Patient Safety Goals
Quality Check
Quality Reporting to The Joint Commission

VIII.   STAFF EDUCATION/ORIENTATION/SUPPORT AND COMMUNICATION

Education of staff regarding patient safety will include:

- Mandatory annual s education and testing regarding the National Patient Safety Goals.
- Orientation processes including specific job related aspects of patient safety
- Training to foster an interdisciplinary collaborative approach to patient safety
- How to report medical/healthcare errors as well as
- How to access support for staff when incidents occur
- Ongoing in-service and other education programs tailored to age appropriate patient populations and designed to be specific for a particular area of expertise.
- Lessons learned and best practices to reduce the risk of patient error

IX.   REPORTING TO GOVERNING BODY

Patient Safety Council:
The purpose of the Patient Safety Council is to provide a forum for hospital leaders to learn about, discuss, prioritize, and develop patient safety programming.
- The Council will meet at least 10 times a year.
- The Patient Safety Council membership is comprised of UMC Administration, Directors, and departmental leaders. Medical staff are invited and encouraged to attend.
- The Patient Safety Officer chairs the meeting.

Annual Patient Safety Plan and Evaluation:
The Patient Safety Officer reviews and updates the Patient Safety Plan annually. The Patient Safety Council reviews the Patient Safety Plan annually and submits it to the Quality and Patient Safety Committee and Governing Bodies.

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 and Board of Trustees.

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

References
Nevada State Health Division, *2011 Legislative Bills* – Senate Bill 339 (SB 339), from
http://health.nv.gov

Hospital-Acquired Conditions (HAC) - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/HACFactsheet.pdf

Nevada Department of Health and Human Services; Nevada State Health Division; *Nevada Sentinel Events Registry* (Nevada Revised Statute (NRS) 439.800-890), from
http://health.nv.gov/Sentinel_Events_Registry.htm

UMC. Serious Reportable Events (SRE)/Sentinel Events (Vol. Administrative Policy I-72)

Policy Title:	Patient Safety Plan		
Location:	Housewide	Policy Section:	Improving Organization Performance
Policy Number:	PI 404	Review Date:	2/04, 4/05, 1/06, 1/07, 1/08, 1/09, 5/10, 7/11, 1/13,1/14
Original Effective Date:	11/2003	Current Effective Date:	1/14

1. **Purpose:**

The purpose of the Patient Safety Plan is to create, maintain and sustain a safety oriented culture for Valley Hospital Medical Center (VHMC). The safety-oriented culture is to provide a clinically safe environment for our patients, visitors, physicians, staff and volunteers.

2. **Policy:**

This safety-oriented culture promotes the identification and reporting of actual events and potential risks to patient safety. VHMC leaders support behaviors and actions that:

- Focus on processes and systems failure when events occur.
- Minimize individual blame or retribution.
- Prevent medical errors or events.
- Conduct proactive risk reduction assessments of high-risk processes based on Sentinel Events Alerts published by TJC or any accrediting agency.
- Communicate events through internal reporting.
- Support sharing and learning of information to affect change in behavior and processes.

A. **Goals:**

- Establish a hospital-wide patient safety oriented culture.
- Implement interdisciplinary education/training of patient safety standards, patient safety checklists, program/plan and individual accountability.
- Improve patient safety though on-going proactive assessment and use of tools such as root cause analysis and failure mode and effects analysis (FMEA).
- Implement immediate response processes to sentinel events.
- Implement response and processes to unanticipated/unexpected events.
- Assess the resource allocations for patient safety
- Analyze safety event data to achieve reduction in events/errors or injury.
- Establish a reporting system that promotes and supports non-punitive actions.

B. **Scope:**

The Patient Safety Plan is a hospital wide plan and is applicable to all departments as defined in the organization chart. The program includes the acute care inpatient services, outpatient, ambulatory services and diagnostic and treatment areas, including sites off the main campus. There are no exceptions to this plan.

This plan is intended to provide a systematic, coordinated and continuous approach to patient safety. Activities and functions of the Patient Safety Plan are integrated within all functions

and activities of patient care and delivery of services. The activities listed below are considered the core activities of this plan but are not limited to these activities:

- Establish visible, consistent focus on patient safety and risk reduction of events
- Assess all medical/health care events ranging from potential events to sentinel events.
- Conduct proactive risk reduction assessments of high-risk processes based on Sentinel Event Alerts published by TJC or any accrediting agency.
- Coordinate and direct activities addressing published Sentinel Event Alerts.
- Train and educate members of healthcare team for patient safety.
- Integrate department and staff participation in the program.
- Assists with Root Cause Analysis for Sentinel Events, or unexpected events
- Conduct proactive risk assessments using failure mode and effects analysis.
- Establish a reporting system that promotes a non-punitive system.
- Focus opportunities on processes and systems and not the individual performance.
- Establish patient safety priorities in the design and redesign of services, processes and systems.
- Assess, measure, analyze safety event data to identify trends, patterns or opportunities for improvement.
- Prioritize patient safety opportunities according to criteria.
- Integrate patient safety activities in Quality Improvement Program.

C. Structure:

Management of the Plan:

This plan is developed, implemented, coordinated and directed by the Patient Safety Officer and the Patient Safety Council. The Patient Safety Council is an interdisciplinary committee comprised of medical staff leaders, administration, nursing, risk management, quality management, pharmacy and infection control. Ad Hoc departments are asked to participate as necessary. The Patient Safety Council functions in collaboration with other hospital and medical staff committees, such as but not limited to; Environment of Care Committee, Pharmacy and Infection Control Committee, Hospital Performance Improvement Committee, and the Medical Executive Committee.

Chair of the Patient Safety Council will be the Patient Safety Officer.
The Patient Safety Council functions as a sub-committee of the Performance Improvement Committee and reports directly to the Medical Executive Committee and to the Governing Board.

3. PROCEDURE:

A. Patient Safety Officer Responsibility:

- Implements, directs all aspects of the Patient Safety Plan.
- Directs development of processes for:

- Sentinel Event Review:
  - Root Cause Analysis
  - Identification of opportunities related to root cause analysis
  - Implementation of improvements
  - Measurement of improvements
- Sentinel Event Alert Review Processes:
  - Assessment of current practice
  - Implementation of improvements
- Conduct proactive risk assessment and failure mode and effects analysis
- Facilitate integration with Risk Management activities
- Facilitate education on patient safety
- Facilitate measurement for safety events, and technology to support program
- Facilitate communication of patient safety findings, opportunities, and improvements throughout the hospital
- Serve as internal expert on patient safety standards for the organization

B. Patient Safety Officer Authority:

Patient Safety Officer has a hospital wide function, with the authority to review, assess, analyze, and conduct root cause analysis or failure mode and effects analysis of any event, process systems that relate to or potential risk to patient safety regardless of department or management structure.

C. Patient Safety Council Goals:

Patient Safety Plan and Patient Safety Plan goals are the same and defined on page one.

D. Integration and Coordination:
The Patient Safety Plan functions in collaboration and integration with all departments, policies and procedures and established plans. This integration is accomplished through interdisciplinary membership on committees, such as, but not limited to; Performance Improvement, Pharmacy and Infection Control Committee and Environment of Care-Safety Committee. The Patient Safety Officer is a member of these committees. This integration is also accomplished through quarterly reports of committee activity to the Hospital Performance Improvement Committee.

E. Communication with Patients:

All patients will receive education related to patient safety, and their environment on point of entry to service/diagnostic area or treatment area. The education will be specific to the area and the patient needs.

In accordance with patient rights, patients and when appropriate family/significant other will be informed about outcome of care, including unanticipated outcomes or when outcomes differ from expected. The attending physician or designee is responsible for

informing the patient and/or family. Additional interdisciplinary members may be included in this communication as appropriate.

F. Staff Education:

Staff will receive education and training during their orientation and on an on-going basis regarding job specific aspects of patient safety, including the need to report medical/health events. The education of the staff will be interdisciplinary teamwork as the delivery of patient care is interdisciplinary.

G. Patient Safety Improvement Activities:

Definition of Terms:
A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or risk thereof," includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

A "near miss" is defined as an unexpected occurrence in which there was no adverse outcome to the patient, but which had the potential to cause serious injury or harm to the patient.

H. Patient Safety Prioritization of Improvement Activities

Improvement activities are prioritized according to set criteria, that includes: compliance related to accrediting standards or error prone or high risk processes, mission/vision/values, strategic/operational goals and cost/benefit analysis. The priorities will be determined in an interdisciplinary committee setting such as Patient Safety Council, Hospital Performance Improvement Committee, Medical Executive Committee and/or the Governing Board.

I. Routine Safety-Related Data Collection and Analysis Incident Report

All departments within the organization (clinical and support) are responsible to report any patient safety events, and potential events by the completion of incident report. This report is then routed to Risk Management. Risk Management screens reports for potential sentinel events or unexpected events/outcomes. Risk Management will communicate on an on-going basis with the Patient Safety Officer/Council regarding clinical events, and/or trends such as patient falls, medication errors, treatment error or unexpected outcomes.

Risk Management will provide data, data analysis of events to the Patient Safety Council on a systematic basis.

Opportunities, patterns or trends will be identified and actions taken for improvement in interdisciplinary committees.

J. **Medication Error**

Medication event data will be collected on an ongoing basis, with analysis of events and actions taken on opportunities.
Surveillance and monitoring will be accomplished through the Medical Management Committee.

K. **Facility Safety Surveillance**

These activities will be accomplished in accordance with the Environment of Care Plans, but will be integrated as appropriate to patient safety.

L. **Staff Perception of and Suggestions for Improving Patient Safety**

A survey of staff, including physicians, all disciplines and support staff, will be conducted at least every two years to seek suggestions for improving patient safety. Staff willingness to report errors will be included in this survey. This data will be analyzed and presented in annual evaluation of program/plan. Opportunities for improvement will be prioritized and implemented through the Patient Safety Council.

M. **Patient/Family Perception of and Suggestions for Improving Patient Safety**

The hospital wide patient satisfaction survey will include questions on patient perception f safety and request for suggestions in safety. This data will be reported quarterly to the Performance Improvement Committee. Opportunities and improvements will be implemented.

N. **Identification, Reporting and Management of Sentinel or Unexpected Event or Outcome:**
Upon identification of a medical/health care event, the patient care provider will:
- Perform necessary health care interventions to protect and support the clinical condition.
- Contact the attending physician and consulting physicians as appropriate, to report error.
- Implement physician orders as appropriate.
- Preserve information related to the event/error.
- Document the facts of the event/error in the medical record according to policy/procedure.
- Report event error to immediate supervisor.
- Immediate supervisor/manager will contact Patient Safety Officer and Risk Management as appropriate.
- Submit an incident report to Risk Management according to policy/procedure
- The Patient Safety Officer and Director of Risk Management will collaboratively review all events/errors that meet the definition of Sentinel Event, Near Miss, Significant Medication Error or unexpected outcomes as appropriate.
- Staff members involved in a sentinel event, near miss, significant medication error or unexpected outcome will receive support regarding staff member's professional and

- emotional reconciliation of event/error. Support may be through Employee Assistance Program.
- Patient Safety Officer, Director of Risk Management and Performance Improvement Manager will determine follow up actions such as, but not limited to root cause analysis and or referral to Peer Review.
- Sentinel Event, Near Miss, Significant Medication Errors, unexpected outcomes will be reported to the Patient Safety Council, Hospital and Physician Performance Improvement Committees and Governing Board, as appropriate.
- Report Sentinel Event to State of Nevada Health Division.

O. Proactive Risk Reduction Activities:

The proactive assessment will include, but not limited to:
- Assess the intended and actual implementation of the process to identify the steps for possible and actual variation using the failure mode and effects analysis.
- For each failure mode, identify the possible effects of the undesirable variation on patients and how serious the possible effect could be.
- For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to the effect may occur. Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or protect patient from the effects of that undesirable variation.
- Test and implement the redesigned processes.
- Identify and implement measures of the effectiveness of the redesigned process.
- Implement a strategy for maintaining the effectiveness of the redesigned processes over time.
- Proactive assessment and action will be reported to the Patient Safety Council, Hospital Performance Improvement Committee and Governing Board as appropriate.
- Communication to leadership, hospital, medical staff committee and departments will be facilitated by Patient Safety Officer.

P. Confidentiality

The Patient Safety Council functions as a subcommittee of the Hospital Performance Improvement Committee. The Quality Improvement Plan confidentiality statement would be applicable to this plan and committee.

Q. Program/Plan Evaluation:

An annual evaluation will be conducted and reported to Patient Safety Committee, Hospital Performance Improvement Committee and Governing Board. The evaluation will include, but is not limited to the following:

- Data from information management needs assessment
- Staff education needs assessment
- Proactive risk assessments

- Incident/event reports
- Sentinel Events
- Root Cause Analysis
- Failure Mode and Effects Analysis
- Patient Satisfaction Surveys
- Staff Survey

Based on the analysis, program/plan and goal revisions will be recommended to the Patient Safety, Hospital Performance Improvement Committee and Governing Board.

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

I.   INTRODUCTION

The Patient Safety Program supports and promotes the mission, vision and values of William Bee Ririe Hospital and Rural Health Clinic through organizational prioritization of patient, visitor and employee safety.

The patient safety program is implemented through the Enterprise Safety Committee and is supported by leadership's promotion of a safety culture that:
- Encourages recognition, reporting, and acknowledgment of risks to patient/visitor and employee safety and medical/healthcare errors
- Initiates/monitors actions to reduce risks/errors
- Internally report's findings and actions taken
- Promotes a blame-free culture facilitating the reporting and follow-up on safety concerns, errors and adverse events
- Educates staff and physicians to assure participation in the program

II.   PURPOSE

The Patient Safety Program is designed to enhance patient care delivery and prevent adverse outcomes of care by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach focuses on actual and potential occurrences; ongoing proactive risk management; and integration of patient safety priorities in the development and revision of processes, functions and services.

III.   MISSION, VISION AND VALUES

In support of the mission, vision and values of this organization the Patient Safety Program promotes;
- Collaboration among staff members, physicians and other providers to deliver comprehensive, integrated and quality health care.
- A focus on comprehensive, integrated quality service

- Open and honest communication to foster trust relationships among staff members, physicians, other providers and patients.

IV. OBJECTIVES

The objectives of the Patient Safety Program are to:
- Encourage organizational learning about adverse or potential adverse events
- Incorporate recognition of patient safety as an integral job responsibility
- Provide patient safety education
- Involve patients in decisions about health care and promote open communication
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate proactive measures
- Report internally any findings and actions taken to reduce risk
- Support sharing of knowledge to effect change
- Supplying support systems to health care workers who are involved in sentinel events.
- Have a sufficient number and mix of individuals to support safe, quality care, treatment, and services.

V. RESPONSIBILITES/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 sentinel events alleged 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 insure 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. Is 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 Mediation 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 are contaminated by toxic substances.

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

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

     6. Radiologic Events

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

     7. Potential Criminal Events

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

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

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

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

VIII. STRUCTURE

The authority for the Patient Safety Plan rests with the CEO, CNO, Quality Improvement Coordinator, Patient Safety Officer, and Chief of Medical Staff and has delegate the authority to implement and maintain activities described in this plan to the Enterprise safety committee.

IX. QUALITY REVIEW INFORMATION

To the extent possible, and in the manner consistent with the protection of confidentiality of quality assurance and patient safety data, pertinent information will be shared between the Quality Improvement Program and the Enterprise Safety Program.

In an attempt to protect quality review information from discovery, all quality review documents must be labeled as a Quality Review document. Documents should be in a formal format, handled by a limited number of individuals and secured in the Quality or Risk Managers Office accessible only to designated individuals. Nevada Revised Statute that protects quality documents is NRS49.265.

X. EDUCATION

Annual Staff and physician/provider education includes but is not limited to the following topics:
- Fire Drills
- Emergency and Disaster Drills
- Workplace violence
- Customer Service
- Creating, implementing, achieving, and maintaining a culture of Enterprise safety
- Risk management and error prevention
- Teamwork

XI. SAFETY IMPROVEMENT ACTIVITIES

Specify Measures Selected for an annual focus; (Examples are listed below)
- Patient satisfaction surveys
- Medical Record review; legible documentation, clear, complete, signed
- Complaints and resolution; to improve care and satisfaction (trends)
- Confidentiality; insure patient and employee information is secure
- Appointments/scheduling process; accessibility to physician
- Informed Consent Policy and Procedure
- Medication management and reconciliation i.e. current allergy information
- Telephone response time to callers
- Occurrence review

Give consideration to measures that facilitate safe practices; (Examples are listed below)
- Involve patients in their health care; consider literacy issues and cultural values, partner with patients in developing and planning their care plan.
- Use a team approach to safety; hold focused safety meetings

- Endorse open, effective communication; identify shared values and attitudes among all members. Interview and/or survey staff for attitudes, perceptions and communication barriers.
- Encourage error reporting to include near miss events. Institute a non-punitive reporting that is confidential and timely.
- Ensure employee and patient information or event reports shared with staff for educational purposes do not identify individuals.
- Facilitate communication skills learning (teamwork)
- Examine physical premises to identify and correct potential hazardous conditions.
- Orient physicians and new employees to risk management and patient safety concepts
- Conduct patient safety rounds
- Provide education and training on high risk processes.

XII. METHODOLOGY

   A. Structure
   - Proactive risk prevention strategies
   - Identification of High Risk Areas
   - General Incidences (Patient Injuries)
   - Potential or actual adverse events (medication errors)
   B. Method – Establish a process for;
   - Identification, Selection, Prioritization
   - Data Collection and Analyses
   - Development of Actions
   - Implementation
   - Reporting
   - Follow-up
   C. Process Improvement – Establish teams/individual staff members to implement processes and to monitor for effectiveness.
   Utilize applicable tools to facilitate improvement; for example
   - PDCA: Plan, Do Check Act with focus on process improvement
   - FMEA: Failure Mode Effect Analysis a systematic process for identifying potential process failures before they occur with the intent to eliminate or minimize risk.
   - RCA: Root Cause Analysis is a retrospective approach to error analysis that identifies what and how the event occurred and why it happened. The focus in on the process and systems not individuals.

XIII. PROGRAM EVALUATION

The Patient Safety Officer will submit monthly a report the Enterprise Safety Committee, Medical Staff and the Board of Directors

1. Definition of the scope of occurrence including sentinel events, near misses and serious occurrences that occurred at WBRH and RHC during the preceding month including;
   - Employee injuries
   - Potential lawsuits
   - Resolutions
   - Recommendations to the decrease of the number and severity of Sentinel Events

Yearly the Patient Safety Officer will submit to the Enterprise Safety Committee, Medical Staff and the Governing Board the following;
a. Detail of activities that demonstrate the enterprise safety program has a proactive component by identifying the high-risk process selected.
b. Results of the high-risk or error-prone processes selected for ongoing measurement and analysis.
c. A description of how the function of process design that incorporates patient safety has been carried out using specific examples of process design or redesign that include patient safety principles.
d. The results of how input is solicited and participation from patients and families in improving patient safety is obtained.
e. The results of the program that assesses and improves staff willingness to report errors.
f. A description of the examples of ongoing education and training programs that are maintaining and improving staff competence and supporting an interdisciplinary approach to patient care.

Yearly the Enterprise Safety Committee shall;
1. Monitor and document the effectiveness of the patient identification policy.
2. Review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility.
3. Revise a patient safety checklist and patient safety policy adopted as necessary to ensure that the checklist or policy reflects the most current standards in patient safety protocols.
4. On or before July 1 of each year, submit a report to the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care. This report must contain;
   - Information regarding the development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted.

XIV.NO CRIMAL PENALTY OR CIVIL LIABILITY

No person is subject to any criminal penalty or civil liability for libel, slander or any similar cause of action in tort if the person, without malice;

- Reports sentinel event to a governmental entity with jurisdiction or another appropriate authority.
- Notifies a governmental entity with jurisdiction or another appropriate authority of a sentinel event.
- Transmits information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority
- Compiles, prepares or disseminates information regarding a sentinel event to a governmental entity with jurisdiction or another appropriate authority; or
- Performs any other act authorized pursuant to NRS 439.800 to 439.890.

NRS439.860 ANY REPORT, DOCUMENT AND ANY OTHER INFORMATION COMPILED OR DISSEMINATED PURSUANT TO THE PROVISIONS OF NRS 439.800 TO 439.890, INCLUSIVE AND SECTION I OF AB 280 IS NOT ADMISSIBLE AS EVIDENCE IN ANY ADMINISTRATIVE OR LEGAL PROCEEDING CONDUCTED IN THE STATE OF NEVADA.

Willow Springs Center
Patient Safety Program / Plan
2016

Making Patient and Staff Safety for 2016 a Priority

As a Patient Safety Officer, I am required to coordinate the safety training to all staff at Willow Springs Center. Along with the entire Leadership team to assure the safety of the milieu for our patients. All staff are entitled to receive and should expect safe working conditions with competent supervision while working at Willow Springs Center. In return, staff is responsible at all times to Willow Springs Center and to their fellow workers to perform all tasks assigned in a safe and professional manner.

The Safety Plan defines processes through which Willow Springs Center provides a safe and healthy environment in which hazards are eliminated and minimized for our patients visitors, and staff which work-related injuries/illnesses are minimized through a program hazard reduction/elimination, i.e., personal protective equipment and education continuous monitoring for safety issues and concerns

The Departments objectives:

- Continually evaluate effectiveness of processes

- Communicate issues to appropriate departments and Risk/Safety officer

- Ensure that staff who participate in safety activities are competent

- Distribute, practice, enforce and review safety plans annually

- Distribute, practice, enforce and review safety policies and procedure every 2 years unless there is a regulatory change

- Encourage the co-operation of all departments in implementing safety

- Engage patients through the "Speak UP" process to bring up concerns about any safety issues

- Encourage the use of the "Bright "Ideas form to suggest areas for improvement in patent are or safety

- Maintain Safety board and Infection Prevention and Control Info Board

- Work with the Infection Control Nurse to provide safety from our Infection Prevent and Control Program to include Hand Hygiene implementing guideline which will also include surveillance. She will report to the PI / safety committee monthly. # of patient admitted, # of Flu shots offered, # of flu shot declined, # of flu shots given, and reason for the declined. Offer Patients and employees Flu vaccine during the Flu season . Employee Goal Rate for 2016 is 71%. Cover your cough program is also educated to each patients.

- All Clinical employees at Willow Springs Center will be required to complete the Suicide Prevention Program annually. Which will include changes and updated SP precaution and documentation.

Orientation

Willow Springs Center supports an ongoing program for employees, an initial safety orientation and annual refreshers thereafter. Staff competency is assessed during safety surveillance, rounds, and annual safety refreshers, and program meetings, random questioning of staff during daily Leadership Rounds

At Willow Springs Center, our most valuable resource is the people who work for us. Most injuries can be prevented. To achieve this objective, Willow Springs Center will make all reasonable efforts to comply with all government/regulatory agencies pertaining to health and safety issues. We require reporting of all injuries, but in the coming year will encourage the reporting of near misses incidents that were prevented but could have resulted in injury. The reporting of near misses will help trends potential areas for injury and safety. The identification of near misses can help facilitate revising systems or environmental areas preventing occurrences from happening. This outline will cover specific areas as discussed in OSHA standards.

I.   OCCUPATIONAL MEDICAL REQUIREMENTS

   A.   <u>Medical Requirements: Staff</u>
         1 TB tests – on hire and annual (2016 Quintaferon Blood test instread of the present process.
         2. Physical exam – on hire
         3. Offered – Influenza
         4. Offered - Hepatitis'
         5. Report injuries on the job – to supervisor and complete employee injury forms

   A -1   **Medical requirements – patients**
         1. TB test on admission – or submit proof of, or x-ray
         2. Lab test as needed /ordered by MD
         3. Hearing and Vision
         4. EKG as needed
         5. X- ray as needed
          6. Offered – Influenza
         7. Immunization records requested by school – placed in school files and
                   Nevada Web-IZ

   B.   **Occupational/ Medical Education Requirements:**
         (1)   Current CPR/AED and First Aid competency (All Direct care Staff)
         (2)   Current licensure (RNs, LPNs, Social Services, Teachers etc.)
         (3)   Medication Administration competency (RNs, LPNs)
         (4)   CPI Hospital policies on handling acting out/violent patients on initial orientation and annually reviewed
         (5)   Physical assessment competency – completed by all nursing staff
         (6)   Fingerprinting and back ground check
         (7)   Restraint and seclusions
         (8)   Keep me Safe
         (9)   Ounce of Prevention
         (10)   Therapeutic Boundaries
         (11)   High Risk Precautions

II.   LOCATION AND USE OF EMERGENCY AND FIRE PROTECTION EQUIPMENT

   A.   Fire alarms/panels
   B.   Fire extinguishers
   C.   Fire keys
   D.   Training
   E.   PPE
   F.   Blood spill kits
   G.   Oxygen/Pulse Ox
   H.   Utility panel/water shut off
   I.   Code Blue boxes
   J.   MSDS Sheets
   K.   Lock out /tag out(select staff trained)

III.   EMERGENCY PROCEDURES

A.   Emergency reporting and evacuation
B.   First Aid training/CPR
C.   Location of MSDS and how to read it
D.   Location of alarms and extinguishers
E.   Disaster protocol internal/external
F.   Seclusion/Restraint protocol
G.   Medical crisis protocol
H.   Needle stick protocol
I.   Oxygen –administering during code blue
J.   Pulse Ox
K.   Elopement
L.   Seizures
M.   Responding to physical distress

IV.   REPORTING UNSAFE ENVIRONMENT

A.   Unsafe conditions – equipment, environmental (i.e., furniture)
B.   Hazards – supplies, unsafe acts
C.   Incidents reports
D.   SIIS forms – Workers Compensation Act
E.   Notifying Supervisor
F.   Utilizing Lock out-tag out for non functioning equipment
G.   Use lock out tag out process

V.   MISHAP REPORTING PROCEDURES

A.   First action – remove patient or staff from dangerous condition, disposition as appropriate, i.e., emergency room
B.   Second action – notify Administrator On-Call who will notify the Risk Management and Director of Nursing
C.   Third action – complete incident report
D.   Fourth action – send incident report to Risk Management
E.   If staff injury – fill out Employee Injury Form/goes with staff to Concentra, or to the emergency rooms.
F.   If patient injury – also notify guardian and physician. RN, will assess and give the information to the physician who will determine to send the patient to the emergency room for further evaluation. Notify the Administrator on call

VI.   INDIVIDUAL RESPONSIBILITIES

A.   Comply with OSHA guidelines
B.   Promptly report safety, fire and health hazards and deficiencies
C.   Promptly report injuries to patients and/or staff to management by completing an Incident Report and or C1.
D.   Maintain proper body ergonomics
E.   Respond to all Code Blue calls, the CNO or designee will observe all calls/report outcome monthly to safety committee
F.   When giving High Alert Medications – 2 RN's /LPN verify dose
G.   Comply with CDC hand washing guidelines
H.   Adhere to continuous rounding of units/document q 15 minutes observations

VII.   PROPER PROCEDURE FOR MANUAL LIFTING (ERGONOMICS)

   A.   Use legs versus back

XII   Infection Prevention and Control

   A. Staff may contact the Infection Preventionish and Control Nurse.
   B   Use of proper Hand Hygiene is stressed with signs posted
   C   We do not have isolation, if a patient requires isolation they are be
       discharged, or if not possible are separated for the other patient and placed on bed rest.
   D. Reportable diseases must be reported to Infection Preventionish and Control Nurse
       she will notify the appropriate external agencies, and report to the Director PI / Risk Management.
   B.   Fill out infection control forms or enter it into Remote Data Entry (RDE) for all
         patients on antibiotics/exception if for acne
   C.   Log all patients on antibiotics in Infection Prevention and Control log -kept in
         Medication room
   D.   Develop Master Treatment Plan for Infection Prevention and Control problem,
         add to problem list.

XIII   Security Management:

   A. Visitors and persons calling the patients must be on the approved
       Visitor/Phone list completed by the guardian, a code word chosen by the guardian
       must be used when taking calls or before visitors come onto unit.
   B. All Staff must wear badges chest high, identifying them as employees
   C.   All visitors must sign in at front desk and wear visitor badge
   D.   Willow Spring's Center, is a locked facility.

XIV   Medical Equipment:

   A. All medical equipment used by nursing is checked- annually
       by certification agency
   B. Staff are to report any non -functioning equipment immediately
       to the CNO, or the Plant Operations department,
       via maintenance request form, or call.
   C. Checked per policy, oxygen-daily, Glucometer – nightly, all other
       equipment is checked Bi-annually for proper functioning, or as needed

XV   Dealing with abusive or violent person(s)

   A. Provide support for staff
   B.   Remove form unit any visitor that is abusive or violent/assess, or
       if police need to be involved. Call administrator on call first, never place hands on
       visitors to remove.
   C. If patient is violent, follow CPI protocol and de- escalation techniques
       assess if police are needed –first call administrator on call

XV   Safety Goals is on- going: related to The Joint Commission National Patient Safety Goals
Requirements
   A. **Patient Identification – two identifiers i.e. picture, ask name,**
                           Lab specimens are labeled in front of patient
   B   **Improve staff communication**:
         1. "Read back" on all telephone orders and critical lab test results
         2. Write the order directly onto the order sheet, then read back to MD

3. Adhere to the do not use abbreviation list
4. Use the SBAR system for a standardized method of communication
   Between caregivers
5. Critical labs are reported per policy of WSC

C **Improve safety of using mediations**

1. Have available list of sound alike / look alike list for current year
   Reviewed annually by the Pharmacist /PT committee/ and Medical Executive Committee
2. Have a list of HIGH Alert medications in each medication room

D. **Reduce the risk of health care associated infections**
   1. Comply with the CDC hygiene guidelines i.e.
      a. Hand washing – 15 sec minimum
      b Cover month when cough – use elbow (hospital suggestion)
   2. Manage sentinel events and Report - deaths/or loss of function

F. **Encourage patients active participation in care and safety**

G **Identify inherent safety risks for patient population**
1. Suicide   2 Elopement   3 Violence as high risk 4) PEER TO PEER interaction 5. Self Harm
6). Sexual Acting Out 7). Suicide Precautions

XVII   Goals for 2016:

1. Follow CDC hand washing guidelines for 2016, monitor Surveillance which will be reported to PI/Safety committee monthly

2. Maintain 3 code blues monthly –mock/or actual
3. Track clinical data related to seclusion and restraints/trend
   and make appropriate revisions based on any trending as appropriate
    a. Continue expectation and goal of decreasing the number procedures

4. Sexual Misconduct Decrease the incidences
5. Confrontation with peers Decrease the incidences
6. Ongoing review of safety and Infection Control policies
7. New Hire and Annual competencies will go on-line (no paper packets)
10. Maintain all NPSG standards
11. Continue to place emphasis on a "non punitive reporting environment

12. Continue video monitoring all High Risk Precaution Events.
13. Improve staff communication related to Performance Improvement data/ place monthly on PI monitor
14. Leadership Team will round the patient care areas